HOSPITALS

HOSPITAL LIBRARY

A Three-Way Partnership in Prepaid Care
—James E. Stuart

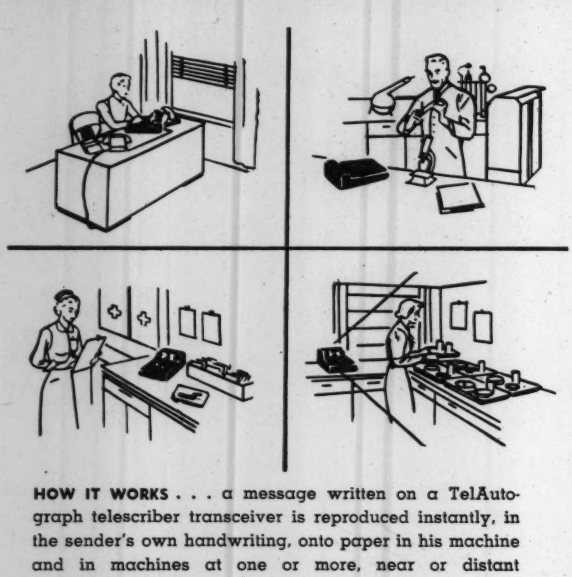
The Most Expensive Bed Is the Empty One
—Martin R. Steinberg, M.D.

Hospitals and the Practice of Medicine
—Robert Cutler

Cooperative Planning of Dietary Services
—U. S. Public Health Service

NOVEMBER • 1951

The Journal of the American Hospital Association



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HOSPITALS

NOVEMBER • 1951

The Journal of

THE AMERICAN HOSPITAL ASSOCIATION

George Bugbee, Executive Director

VOLUME 25 NUMBER 11

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A Half Million Dollars Was Just A Dream . . .

Examples of Recent Campaigns

Holzer General Hospital
Gallipolis, Ohio

Population—7,832
Goal $500,000
Raised $540,000

St. Luke's Hospital
Fargo, N. D.

Population—32,580
Goal $390,000
Raised $432,683

Holden District Hospital
Holden, Mass.

Population—3,924
Goal $150,000
Raised $262,000

Genesee Memorial Hospital
Batavia, N. Y.

Population—17,267
Goal $300,000
Raised $310,914

Annapolis General Hospital
Annapolis, Md.

Population—13,069
Goal $350,000
Raised $502,000

• • • **for Holzer Hospital** in Gallipolis, Ohio until after they engaged Haney Associates to direct their half-million dollar campaign for funds to enlarge.

Dr. Charles Holzer, Chief of Staff writes . . .

"MORE than anything else we appreciate the manner in which the work was done. Your representatives . . . left the entire community happy and satisfied with the results. I think that it is really remarkable that an organization can come into a community, raise large sums of money from its citizens, and have these citizens express regret that they are leaving, yet this is what happened."

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HOSPITAL ASSOCIATION and ALLIED MEETINGS

AMERICAN HOSPITAL ASSOCIATION

54th Annual Convention—Sept. 16-19, 1952; Philadelphia.

Mid-Year Conference, American Hospital Association—Feb. 8-9, 1952; Chicago (Drake Hotel).

REGIONAL MEETINGS

Carolinas-Virginias Hospital Conference — April 24-25, 1952; Roanoke, Va. (Roanoke Hotel).

Catholic Hospital Association—May 26-29, 1952; Cleveland (Public Auditorium).

Maryland-District of Columbia-Delaware Hospital Association—Nov. 26-27; Washington, D. C. (Statler Hotel).

Middle Atlantic Hospital Assembly—May 21-23, 1952; Atlantic City (Convention Hall).

Mid-West Hospital Association—April 23-25, 1952; Kansas City, Mo. (President Hotel and Municipal Auditorium).

New England Hospital Assembly—March 24-26, 1952; Boston (Statler Hotel).

Southeastern Hospital Conference—April 16-18, 1952; Atlanta (Atlanta Biltmore Hotel).

Tri-State Hospital Assembly—April 28-30, 1952; Chicago (Palmer House).

Upper Mid-West Hospital Conference—May 14-16, 1952; St. Paul (Lowry and St. Paul hotels).

Association of Western Hospitals—May 12-15, 1952; San Francisco (Civic Auditorium).

STATE MEETINGS

Arkansas—May 5-6, 1952; Hot Springs (Arlington Hotel).

California — November 28-29; Coronado (Hotel del Coronado).

Colorado—November 8-9; Denver (Shirley-Savoy Hotel).

Florida—Dec. 3-4; Orlando (Wyoming Hotel).

Georgia—Feb. 7-8, 1952; Atlanta (Atlanta Biltmore Hotel).

Illinois—Nov. 14-15; Springfield (Abraham Lincoln Hotel).

Kansas—Nov. 8-9; Topeka.

Kentucky—March 25-27, 1952; Louisville (Seelbach Hotel).

Massachusetts—Jan. 15, 1952; Boston (Copley-Plaza Hotel).

Michigan—Nov. 11-13; Grand Rapids (Pantlind Hotel).

Missouri—December 6; St. Louis.

Nebraska—Nov. 15-16; Omaha (Fontenelle Hotel).

New Jersey—May 21-23, 1952; Atlantic City (Convention Hall).

Ohio—March 31-April 3, 1952; Cleveland (Cleveland Hotel).

Oklahoma—Nov. 1-2; Tulsa (Mayo Hotel).

Rhode Island—December 13; Providence (Miriam Hospital).

Texas—May 20-22, 1952; Houston (Shamrock Hotel).

Wisconsin — Feb. 14, 1952; Milwaukee (Schroeder Hotel).

OTHER MEETINGS

American College of Clinic Administrators—Jan. 13-15, 1952; Chicago (Stevens Hotel).

American College of Surgeons—Nov. 5-9; San Francisco.

American Protestant Hospital Association, Feb. 21-22, 1952; Cleveland (Statler Hotel).

Blue Cross-Blue Shield Annual Conference—March 31-April 3, 1952; San Francisco (Fairmont and Mark Hopkins hotels).

National Association of Methodist Hospitals and Homes—Feb. 20-21, 1952; Cleveland (Statler Hotel).

INSTITUTES

(For additional information address Association headquarters, 18 E. Division Street, Chicago 10.)

Institute on Establishment—Nov. 5-9; Washington, D. C. (Wardman Park Hotel).

Institute on Personnel Relations—Nov. 5-9; Richmond, Va. (John Marshall Hotel).

Institute on Laundry Management—November 26-30; Boston (Somerset Hotel).

Institute on Financial Administration of the Proprietary Hospital — November 5-9; Houston (Rice Hotel).

Institute on Nursing Service Administration —December 3-7; Chicago (Knickerbocker Hotel).

Institute on Medical Record Libraries—Jan. 14-18, 1952; Baltimore (Sheraton-Belvedere Hotel).

Institute on Personnel Administration—Jan. 21-25, 1952; Santa Barbara, Calif. (Mar Monte Hotel).

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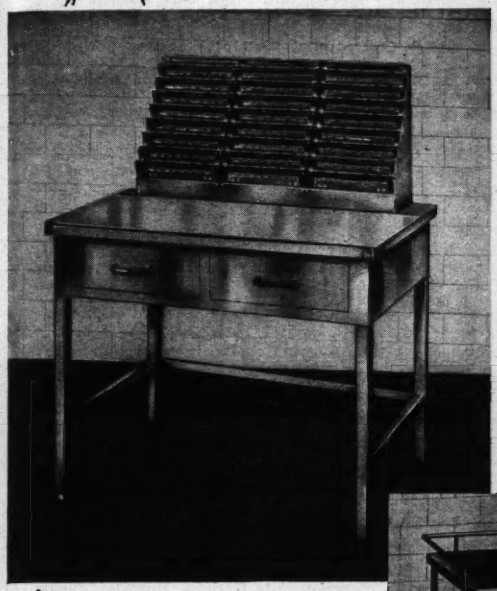
A Record...FOR EFFICIENCY • DURABILITY • APPEARANCE

Blickman-Built Stainless Steel Chart Desks and Carriers Assure Long Service Life and Low Maintenance Cost



• Many leading institutions have standardized on Blickman-Built Nurses' Desks, Chart Racks and Carriers. They have found that this gleaming stainless steel equipment outlasts ordinary units many times over. Furthermore, maintenance expense and replacement costs are eliminated. The solid, lustrous surfaces never require painting or refinishing. Cleaning is easy and the attractive new-look appearance endures for the life of the unit. Sturdy, all-welded construction assures a permanence and durability that cannot be matched by ordinary equipment. In addition, these Blickman-Built units have many features of design and construction which provide extra security and efficiency in handling vital records. Compare this equipment with any similar-purpose units on the market. You, too, will be convinced that, from every standpoint, they are the wisest investment you can make.

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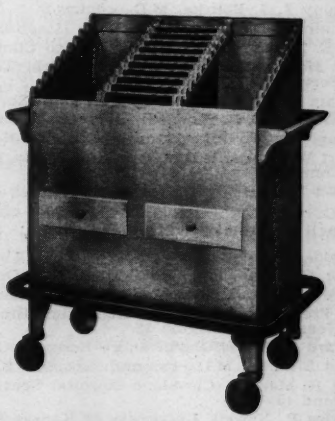
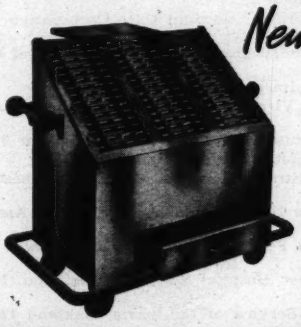
All-welded construction. Double-walled, roller-bearing, flush-front drawers. Sizes for 20, 30, or 40 chart holders.

ROBERTS Stainless Steel NURSE'S DESK
Attractive appearance. Durable, all-welded construction. Sound-deadened top. 4 flush-fitting, roller-bearing drawers.



RODNEY STAINLESS STEEL CHART CARRIER
Can be wheeled from bed to bed as doctor makes rounds. Ball-bearing swivel casters; continuous rubber bumper. Sizes for 20, 30, or 40 chart holders.



New **CHART-LOCKING CARRIER**

COMMANDER CHART CARRIER
No unauthorized person can remove charts. They are locked in with a 2-way key-in-handle lock. Welded, stainless steel construction throughout. Bracket-supported drop-type writing shelf. Two-compartment drawer for forms and records. Heavy-duty disc-type casters. Continuous rubber bumper. Sizes to accommodate 30, 45, or 60 charts.

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illustrating and describing in detail many different models of chart desks, carriers and holders.

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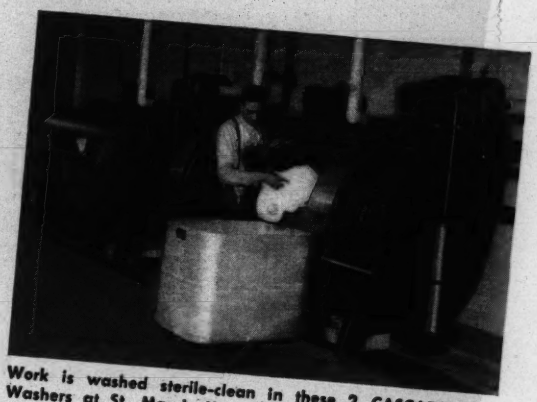
New "AMERICAN" Laundry . . .

Cuts work week 14 hours

at St. Mary's Hospital Orange, N. J.

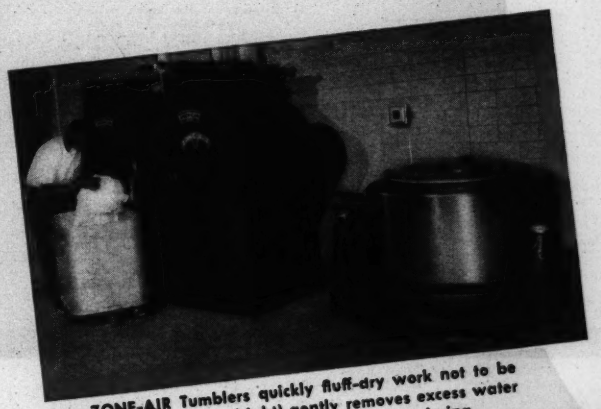


Work is washed sterile-clean in these 2 CASCADE Washers at St. Mary's Hospital.

Constantly striving for more efficient operation, management of 140-bed St. Mary's Hospital decided to install a new AMERICAN laundry department.

Our Laundry Advisor was called in to study their clean linen needs and recommend a layout for the new laundry building. After careful analysis, he recommended new AMERICAN equipment necessary to assure economical operation for years to come. Since installation of this equipment, the Hospital **has reduced the laundry work week 14 hours.** Faster return of linens to service . . . better quality work . . . less wear and tear on linens, are other benefits reported.

The free services of our Laundry Advisor are available to hospitals, large or small, **without any obligation whatever.** He will call at your convenience and make a comprehensive survey to determine the benefits you can expect by modernizing your laundry, or with a new AMERICAN planned laundry dept. WRITE TODAY . . . for our Laundry Advisor to call.



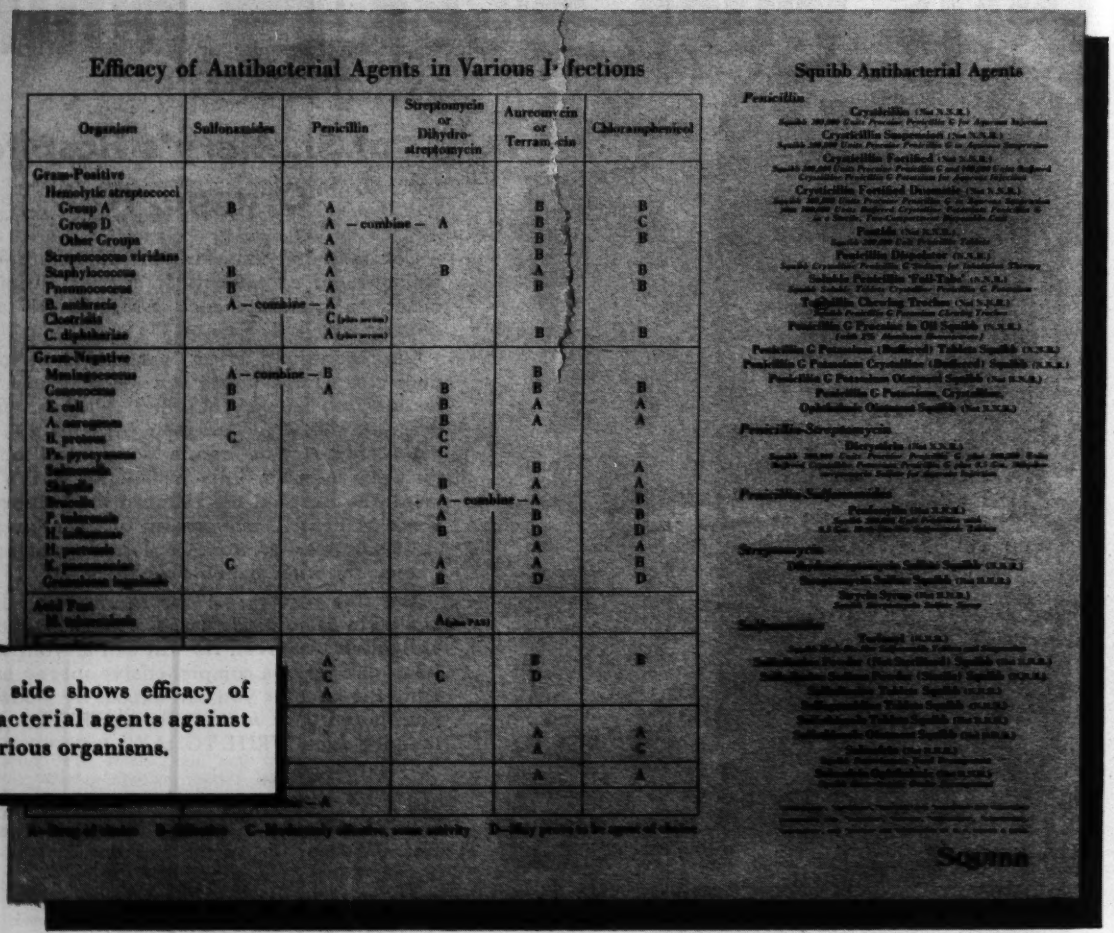
Two ZONE-AIR Tumblers quickly fluff-dry work not to be ironed. O. T. Extractor (right) gently removes excess water from linens to prepare them for ironing or drying.

Remember . . . **Every Department of Your Hospital Depends on the Laundry.**

Linens are beautiful ironed, in the shortest possible time, on this 4-Roll STREAMLINE Flatwork Ironer.

The
AMERICAN
LAUNDRY MACHINERY CO.
CINCINNATI 12, OHIO

New Antibacterial Chart



Efficacy of Antibacterial Agents in Various Infections

Organism	Sulfonamides	Penicillin	Streptomycin or Dihydrostreptomycin	Aureomycin or Terramycin	Chloramphenicol
Gram-Positive					
Hemolytic streptococci					
Group A	B	A		B	B
Group D		A — combine —	A	B	C
Other Groups		A		B	B
Streptococcus viridans		A		B	
Staphylococcus	B	A	B	A	B
Pneumococcus	B	A		B	B
B. anthracis	A — combine —	A			
Clostridia		C (also serum)			
C. diphtheriae		A (also serum)		B	B
Gram-Negative					
Meningococcus	A — combine —	B		B	
Gonococcus	B	A	B	B	B
E. coli	B		B	A	A
A. aerogenes			B	A	A
B. proteus	C		C		
Ps. pyocyaneus			C		
Salmonella				B	A
Shigella			B	B	A
Brucella			A — combine —	A	B
F. tularensis			A	B	B
H. influenzae			B	D	D
H. pertussis				A	A
K. granulomatis	C		A	A	B
Granuloma inguinale			B	D	D
Acid Fast					
M. tuberculosis			A (also PAS)		
		A		E	B
		C	C	D	
		A			
				A	A
				A	C
				A	A
		— A			

A—Drug of choice B—Effective C—Moderately effective, some activity D—Likely proven to be agent of choice

Squibb Antibacterial Agents

Penicillin

Crystillin (Not N.N.R.)

Crystillin Suspensoid (Not N.N.R.)

Crystillin Fortified (Not N.N.R.)

Crystillin Fortified Dessicate (Not N.N.R.)

Pentids (Not N.N.R.)

Penicillin Dispenser (N.N.R.)

Penicillin "Pull-Tube" (N.N.R.)

Tablets Penicillin Chewing Troches (Not N.N.R.)

Penicillin G Procaine in Oil Squibb (N.N.R.)

Penicillin G Procaine (Buffered) Tablets Squibb (N.N.R.)

Penicillin G Potassium Crystalline (Buffered) Squibb (N.N.R.)

Penicillin G Potassium Ointment Squibb (Not N.N.R.)

Penicillin G Potassium, Crystalline, Ophthalmic Ointment Squibb (Not N.N.R.)

Penicillin-Streptomycin

Diosporin (Not N.N.R.)

Penicillin-Sulfonamides

Penfurvin (Not N.N.R.)

Streptomycin

Dihydrostreptomycin Sulfate Squibb (N.N.R.)

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Squibb Syrup (Not N.N.R.)

Sulfonamides

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Sulfathiazole Powder (Not Buffered) Squibb (Not N.N.R.)

Sulfathiazole Sodium Powder (Buffered) Squibb (N.N.R.)

Sulfathiazole Tablets Squibb (N.N.R.)

Sulfamerazine Tablets Squibb (N.N.R.)

Sulfathiazole Tablets Squibb (Not N.N.R.)

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Front side shows efficacy of antibacterial agents against the various organisms.

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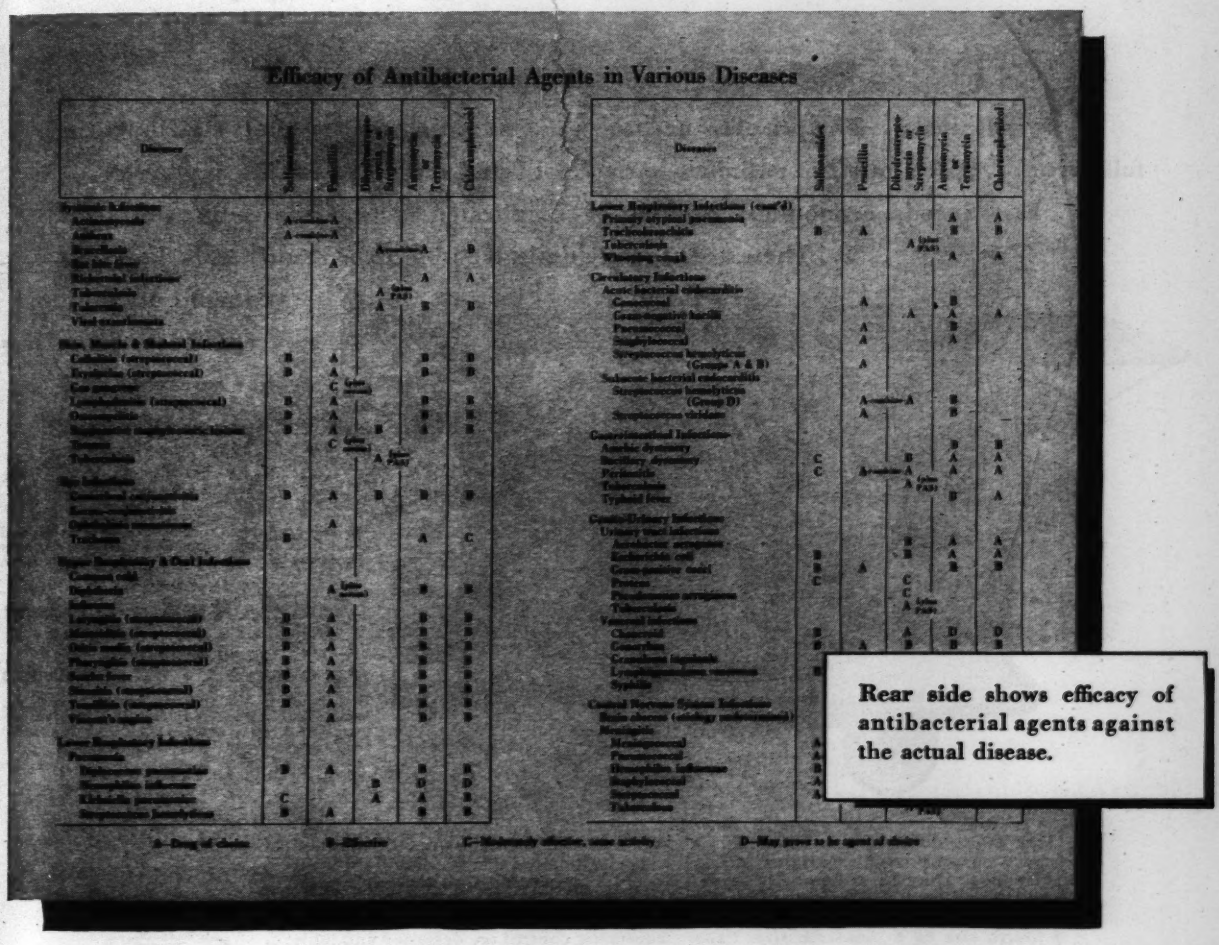

Rear side shows efficacy of antibacterial agents against the actual disease.

The chart, 8½ x 11 inches, may be hung on the wall in the pharmacy, posted on the bulletin board, placed under the glass on a desk, or wherever it is most convenient. Your Squibb Professional Service Representative will provide you with this chart, or any other Squibb visual or practical aids, without cost or obligation, or you may write direct to:

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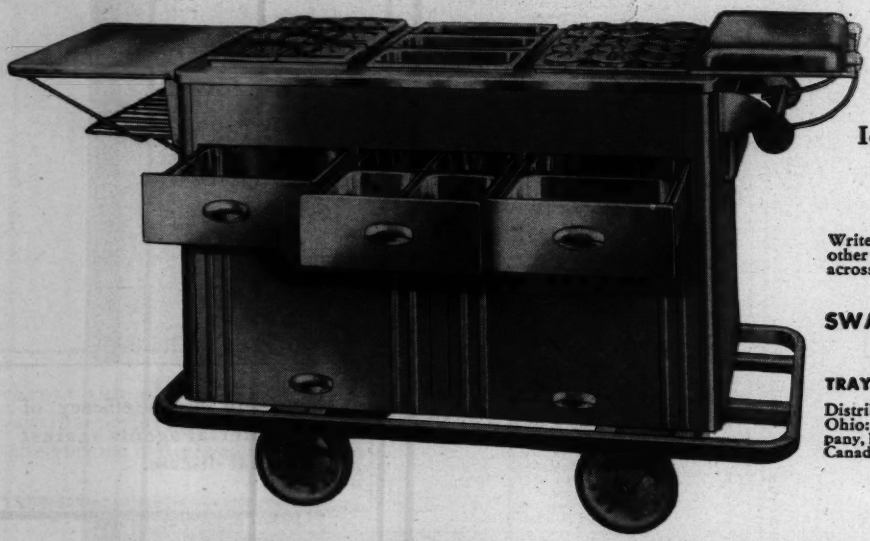

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TRAY CONVEYORS • HOT PACK HEATERS

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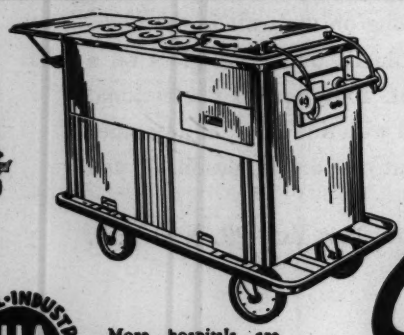
Over 2000 different combinations of food pans are possible with this Model 1003 Extra Duty Ideal Food Conveyor. Each 12 x 20 inch well accommodates 1 full size pan, 2 half size, 3 third size, 4 fourth size or 6 one-sixth size. Pans may be 2, 4, or 6 inch deep. Three 12 x 20 inch heated drawers give added capacity for special food. Standard Ideal Diet Trays will fit both top deck wells and drawers. Sag-proof top deck, easy handling, and cleaning, ample safety; automatic control are designed and built into this as into all other Ideal units.



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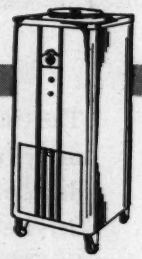

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A research development of C.S.C. Pharmaceuticals, Compenamine is generically designated as *l*-ephenamine penicillin G. Its clinical behavior and therapeutic performance are identical, unit for unit, with comparable dosage forms of procaine penicillin. Nearly insoluble in water and oil, its dosage forms are of the repository type.

Compenamine is priced identically with procaine penicillin G. Hence economic considerations are no obstacle to its routine use.

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COMPENAMINE IS CURRENTLY AVAILABLE IN THREE REPOSITORY DOSAGE FORMS:

- COMPENAMINE (for aqueous injection), in vials.
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AS OUR VERY GOOD friend Dr. Wilinsky wrote the twelfth and final column of his year as president, he described your writer as a "genial personality." Thanks very much, Charlie. I appreciate this descriptive phrase but feel far from genial when I think I have 12 columns to write that might compare with the 12 excellent columns you wrote during your presidency.

Also, thank you very much for the year of training you gave me as president-elect to step into your shoes.

ST. LOUIS IS A MEMORY to most of us, and those of us fortunate enough to be able to attend the annual convention also feel that it was an educational experience which is not available in any other form. We owe a great deal of gratitude to our exhibitors for the convenient and pleasing manner in which they made material and information available for our inspection.

One of the outstanding actions of the House of Delegates during our meeting was the approval of our participation in the Joint Commission on Hospital Accreditation. This action will mean a considerable amount of work for the Board of Trustees, our executive director and headquarters staff. How rapidly this program will be able to move forward cannot be said but it certainly appears that some time during the first quarter of 1952 we will see some tangible results.

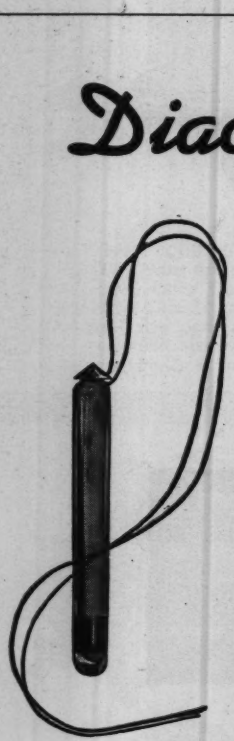
I SHOULD LIKE to use this column to express my heartfelt appreciation to the many of you who extended good wishes and offers of assistance at St. Louis and also for the many letters I have received since returning to San Francisco. I certainly promise to do my very best.

UPON MY RETURN I found the usual amount of work stacked up on the desk, and it took Saturday, Sunday and Monday to clear it up.

Thursday morning it was one airline to Salt Lake City, and another to Pocatello, where I took part in the Idaho State Hospital Association meeting. A great amount of interest was shown in the action of the American Hospital Association on hospital accreditation. There is something intimate and enjoyable about a state hospital association meeting. It was particularly pleasant to see our former assistant, John Tiernan, who was program chairman for the convention and also is superintendent of the Pocatello General Hospital. Time was short, but on our way to the airport he drove me by his new hospital, which will be open soon. It was built with the assistance of Hill-Burton financing. It certainly is a great addition to Pocatello, and naturally John is chafing at the bit waiting to get into his new quarters.

NEXT STOP ON THE president's circuit took me to the Hotel Commodore in New York City, where I took part in the Conference on Women in the Defense Decade. I ended up in a section on health. A great deal of discussion centered

Diack Controls



Foundation in Fact

The use of Diack Controls has increased *5 fold* from 1940 to 1950.

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Diack Controls
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A Curity PRODUCT

BAUER & BLACK

45% reduction in skin irritation with new Curity Adhesive

The incidence of irritation was about half that of all other leading brands in impartial clinical tests.*

There has been a rather sensational improvement in adhesive tape, and you will be interested in the story behind it.

In 1937, after many years of research aimed at reducing skin irritations caused by adhesives, the makers of *Curity* Adhesive made a major change in the composition of the adhesive mass. Contemporary tests in a well-known university's dermatology department proved Curity was the least irritating of all leading brands.

That 1937 report was encouraging, but we were not yet satisfied. Though we had reduced skin irritation to a degree not previously believed possible, we kept right on working to produce an even more satisfactory adhesive.

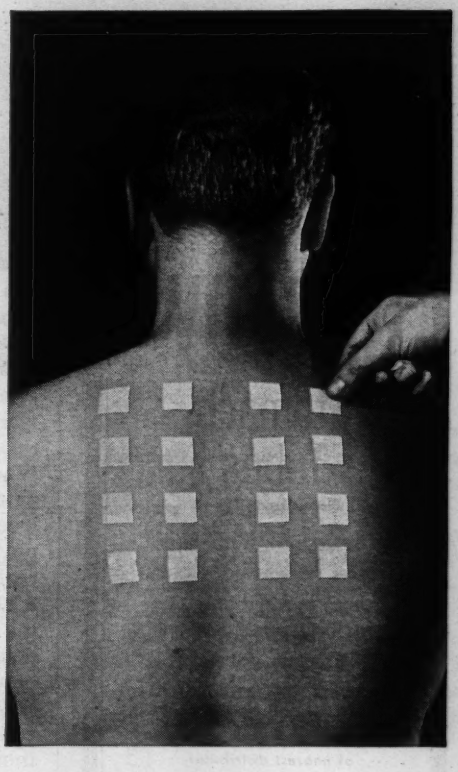
As a result of constant study we have now developed a new adhesive that cuts irritation just about in half. This is the largest single step ever taken in adhesive improvement.

To test the precise degree of this tremendous improvement, we commissioned a leading New York laboratory to test the new *Curity* Adhesive. Its report follows:

Proportion of individuals who react to adhesive:

	7-Day Test
New CURITY	18.2%
Former CURITY	33.2%
Brand No. 1	38.4%
Brand No. 2	35.0%

Figures include even minor erythema, not usually counted in test reports.



STICKS BETTER, TOO

Using sixteen assorted adhesive patches per individual in irritation tests, it was also noted that new *Curity* Adhesive stuck more easily and stayed on better than any other brand tested. This, then, would appear to be the best adhesive available to the profession today.

*Report by Killian Laboratory—summary available upon request.

new Curity ADHESIVE

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You can feel the difference and so can the patient

LOW COST EXPENDABLE

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Stomach Tubes

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Satin-smooth, transparent
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BAXTER

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around nursing education and the shortage of nurses. During the luncheon on Friday, Rep. Frances Bolton gave a splendid talk on the place of women in present-day life — in the home, in industry, in the professions and in all sorts of defense activities. Mrs. Bolton is an excellent orator and presented her material with great ease, which indicated her long years of experience before a microphone.

SATURDAY I ATTENDED a meeting of the Inter-Association Committee on Health. This committee has been in existence for the past few years and is composed of several of the largest national organizations in the health field. Subjects of common interest are discussed and considerable time is given to current legislation in the health field on a national level.

Then it was back to San Francisco, where another batch of work had accumulated, and at this writing I am trying to catch up in order to leave in a few days for the Montana state meeting at Billings.

I AM SURE THAT a great many of you have been attending conventions much longer than I. My first took place in St. Louis in 1935, and I have been fortunate enough to attend each one since that time. I was greatly impressed by the way this affair has increased in size. When I think of the amount of detail necessary for the two-week post-graduate course for 100 physicians at Stanford, I begin to realize that a convention for some 8,500 people, with many things going on at once, must require more detail work than I can possibly envisage.

To those of us who are interested in administration and organization, it is most impressive to see George Bugbee's team at work during the week. Every person seems to have his proper assignment, there seems to be no overlapping, apparently harmony reigns and each day of the convention fits beautifully into the over-all pattern.

We people in hospital administration know full well that it takes weeks and months of scrimmaging to put such a team in the field for the week of the convention, and we can all appreciate the tension which must go with it. Don't you wonder what must be in their minds on the Friday, Saturday and Sunday after the convention is over? With this thought in mind, I would like to say—Orchids to George Bugbee and the staff.

MY CONCEPTION of a column(ist) is something tall and lanky. I wonder if I fill this bill in your eyes!

Anthony J. J. Rourke

Anthony J. J. Rourke, M.D., President
American Hospital Association

On the job!

Our volunteer speakers are saving thousands of lives *today* . . . in factories and business offices . . . at neighborhood and civic centers . . . at social, fraternal and service group meetings all over this land . . . by showing people what they can do to protect themselves and their families against death from cancer.

To find out what you yourself can do about cancer, or if you want us to arrange a special educational program for your neighbors, fellow-workers or friends, just telephone the American Cancer Society office nearest you or address a letter to "Cancer," care of your local Post Office. One of our volunteer or staff workers will be on the job to help you.

American Cancer Society

Mind if we talk about your operation?

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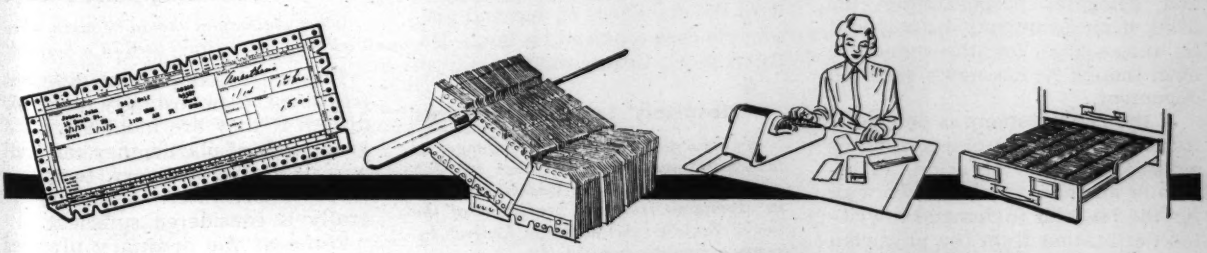
With other McBee systems, a hospital can put its payroll, accounts receivable, inventory and cost recovery operations on a business-like basis.

The McBee representative near you can analyze your record-keeping problems and show you how McBee can help. Ask him to drop in. Or write us.



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SERVICE FROM HEADQUARTERS

Fans in operating rooms

Will the use of an exhaust fan in an operating room reduce the concentration of explosive gas at the patient's head?

There is no reason to believe that the use of an exhaust fan will materially reduce the concentration of explosive gas mixtures immediately at the head of the patient, where the maximum danger lies. In my estimation, the exhaust fan would serve only to reduce explosive concentration of gases in the event of a gross leak. Such is most unlikely to occur while the operating room is populated.

If an exhaust fan is used, its arrangement is controlled by the following sentence of the National Fire Protection Association standard:

"Regardless of location, fans should be of a type approved for use in explosive atmospheres. Motors installed in hazard areas should be of a type approved for use in explosive atmospheres and should be installed outside of the ducts."—ROY HUDENBURG.

Signing medical records

A physician at our hospital signs medical records with a rubber stamp rather than by hand. Is this acceptable practice in hospitals?

If a physician chooses to declare that a rubber stamp shall be his legal signature, then it must be accepted as such and will be so regarded by any court in case of argument. The rubber stamp is legal, entailing the responsibility of the person whose signature it represents.

If the physician places the stamp in the possession of someone else and delegates responsibility for using it on documents, he still will be responsible for the signature even though he has never seen the document.

If the rubber stamp is delegated to some hospital employee such as a medical record librarian, an intern or a resident, it would be wise for the hospital to demand a written declaration from the physician that he has given permission to another person to use the stamp.

As a matter of sound hospital practice, however, the use of a rubber stamp should be discouraged. A medical record is an important document having many legal implications. If the doctor signs other important documents, such as checks, with the stamp, then the hospital will be obliged to accept the signature. The method is too open to abuse to permit all physicians in a hospital to use it.

Unless there is some valid reason why the physician cannot sign the documents in his own handwriting, the hospital should insist he sign each record by hand.—DR. CHARLES U. LETOURNEAU.

Written consent for surgery

Is a hospital responsible for obtaining a patient's written consent for operation?

An operation performed by a surgeon is a contract between the surgeon and the patient. The hospital does not enter into this contract, but makes a separate contract with the patient for use of the operating room facilities, for which a fee is charged.

The contract of surgical operation requires consent on both sides. It is the duty of each party to obtain consent of the other. While many hospitals secure the written consent of a patient as a courtesy to the surgeon, it is his duty to see that consent has been obtained before he operates, otherwise he will be liable for technical assault amounting to battery, perhaps mayhem.

The hospital also may be responsible to the patient for permitting irregularities in the operating room. If the hospital has definite rules and regulations requiring all patients to give a signed authorization before operation, it would seem that the hospital has complied with the standards of due and reasonable care required by law.—DR. CHARLES U. LETOURNEAU.

Hospitals' tax-exempt status

Would a nonprofit hospital endanger its tax-exempt status under Section 101 (6) of the Internal Revenue Code if it waives its exemption from the provisions of the Social Security Act and the Federal Insurance Contributions Act?

No. Under the terms of the 1950 amendments to the Social Security Act, participation in the Old Age and Survivors Insurance program was made completely voluntary for nonprofit hospitals and their employees. The hospital must waive its exemption from the special provisions of the Internal Revenue Code regarding social security contributions, and this waiver certificate must be signed by two-thirds of the employees. The waiver may be withdrawn by the hospital upon two years' notice at any time after 10 years' participation. This voluntary aspect negates the compulsory nature of the tax.

The American Hospital Association fully realizes the importance of the tax-exempt status of nonprofit hospitals and would not have endorsed the Old Age and Survivors Insurance program unless it had reasonable assurance that no invasion of tax exemption would result. The Association's Board of Trustees urged all nonprofit hospitals to participate in the program. While we do not have exact figures on the number of hospitals that have joined the program, we believe a majority of the nation's nonprofit hospitals have taken advantage of this program for the benefit of their employees. —ALBERT V. WHITEHALL.

Hospital literature index

Is there an index to hospital literature similar to the "Quarterly Cumulative Index Medicus," which indexes medical literature?

The Library of the American Hospital Association prepares a semi-annual "Index of Current Hospital Literature," now in its seventh year.

The index covers nearly 150 journals in the fields of hospital administration, nursing, medicine, health and related subjects. The subscription rate is $3 a year.

In 1949 a cumulation of literature of the five previous years was prepared. This index is still available at $5 a copy.—HELEN T. YAST.

Sterilizing plastic trays

What precautions should be taken when sterilizing plastic trays used in a hospital?

Plastic trays require no different treatment than ordinary trays or dishes. If they are molded from a good grade of plastic, they can well withstand the ordinary temperatures of dishwater. Washing generally is considered sufficient.

None of the ordinary plastics will stand temperatures above 200 degrees. They should be submitted only to about 170 or 175 degrees, the usual temperature used in dishwashing.—LEONARD P. GOUDY.

***Now**—the Swift's Meats for Babies physicians know and recommend in this 3½-oz. size is available in*

new, convenient institutional size!

12 Ounces — 7 Varieties

The palatable, economical way to provide protein supplementation for adult patients on soft diets!

Here's the product everyone asked us for! The original Swift's Meats for Babies are now available in a special 12-ounce institutional size. Convenient and economical for use in hospitals, nursing and convalescent homes, and other institutions.

These are the Swift's Meats for Babies which so many physicians have been using and recommending for years—in geriatrics feeding, ulcer management, pre- and post-operative care—any special condition where protein supplementation presents a problem.

All seven tempting varieties come in the new 12-ounce size: beef, lamb, pork, veal, liver, heart, and liver and bacon. The individual particles of meat are strained so fine that Swift's Strained Meats may even be used in tube feeding!

Swift's Strained Meats provide an excellent source of biologically valuable proteins, B vitamins and food iron in a palatable, natural form that soft-diet patients really appreciate—and *eat with pleasure!*

Ready to serve at a saving! These expertly prepared meats save time and cut labor costs in the special diet kitchen. Swift's Strained Meats are easy for patients to obtain after leaving the hospital—they are available at all food stores in 3½-ounce sizes in the baby food section.

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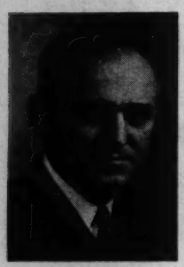
opinions

ON FEDERAL AID FOR NURSING EDUCATION

IN AN ATTEMPT to prevent an estimated shortage of 49,000 nurses by 1954, Rep. Frances P. Bolton (R., Ohio) has introduced a bill calling for $47,000,000 a year in federal aid for nursing education. The bill has evoked arguments on the necessity of asking the government to help solve the problem. Eight hospital executives, who are, or were until recently, members of the Board of Trustees and/or the Coordinating Committee of the American Hospital Association, present their ideas in answer to the question: "In view of the current supply of graduate registered nurses and nonprofessional auxiliary nursing personnel, what is your opinion of the desirability of federal aid for nursing education?"

Additional funds needed to end nurse shortage

FOR MANY YEARS additional financing has been needed for the proper support of nursing education. The needs and the fact that they have not been met have been accentuated as never before during the past two years.



DR. CROSBY

There is a shortage of nurses in all categories. Badly needed beds are closed because of the lack of sufficient bedside nurses. Schools of nursing are having difficulty in obtaining properly trained instructors and supervisors.

More funds are needed for nurse recruitment programs; the financial structure of schools, both diploma and collegiate, must be strengthened, and studies to determine future needs for nursing and the most efficient utilization of nursing personnel in the health fields must be carried out.

More nurses must be trained—and they will not be unless sufficient funds are available—if we are to maintain our standards in civilian hospitals, to say nothing of supplying the numbers needed by the armed forces and other governmental services.

There has been a difference of opinion as to how the funds may be obtained. Substantial amounts have been obtained on the local level for scholarship funds. There has been success at last in securing funds for the Committee on Careers in Nursing of the American Hospital Association.

There not only has not been enough money provided to meet expanding needs in nursing for normal hospital and community requirements, but now we are faced with a national and international crisis that has increased every phase of the problem.

It is for these reasons—and others not listed—that I support a policy of seeking federal financial aid for nursing education.—DR. EDWIN L. CROSBY, *director, the Johns Hopkins Hospital, Baltimore.*

Federal aid logical, but not the present Bolton Bill

IT IS ESTIMATED that nursing education costs the hospital school of nursing a total of $200 per student each year, after giving proper credit for every hour of service the student has rendered in the hospital and after her tuition fees.

MR. HEERMAN

Approximately 50,000 students are in training annually. The cost to patients, therefore, must be more than $10,000,000 each year. This cost should be spread to the general public who benefit. The American Hospital Association could spread this amount to all hospitals using nurses by a direct increase in dues, but this method would be impractical. The logical solution is subsidy from tax money since government does provide education to all people.

State aid would not be practical because many states can aid only government agencies. It is logical, therefore, that federal aid be secured with minimum control. This method would be more satisfactory than for the government, through its hospital system, to establish schools of nursing and come into socialized control of nursing education.

The present Bolton Bill to provide federal aid to nursing education is not satisfactory, but there is no reason why doctors, nurses and hospital people cannot produce suitable legislation.—RITZ E. HEERMAN, *superintendent, California Hospital, Los Angeles.*

Federal program should be flexible at local level

A DECISION REGARDING the desirability of federal aid for nursing education should be based upon: (1) The present nursing situation throughout the country; (2) the probable trend in nursing education and nurse procurement; (3) the role that federal aid might take in relieving the nursing shortage, and (4) the conditions under which aid might be given.

DR. SNOKE

The lack of general duty nurses and of nursing directors, supervisors and educational directors is one of the most serious problems facing hospitals today and many hospitals are in a desperate situation because of this.

The current trends of improvement of standards, accreditation requirements, and alterations in the curriculum are all in the direction of decreasing the amount of nursing service given the patient and the hospital by the student nurse. While I agree that these present-day trends are desirable, I cannot emphasize too strongly that it is raising havoc with nursing service in the hospital and with the hospitals' operating budget.

As the student nurse service is withdrawn from the patient, the hospital must replace it with salaried graduate nurse service and nonprofessional civilian nursing help at an increase in the hospital budget but with no decrease in nursing school expense. The

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May we send you a copy of this 12-page brochure? It gives the complete story of the

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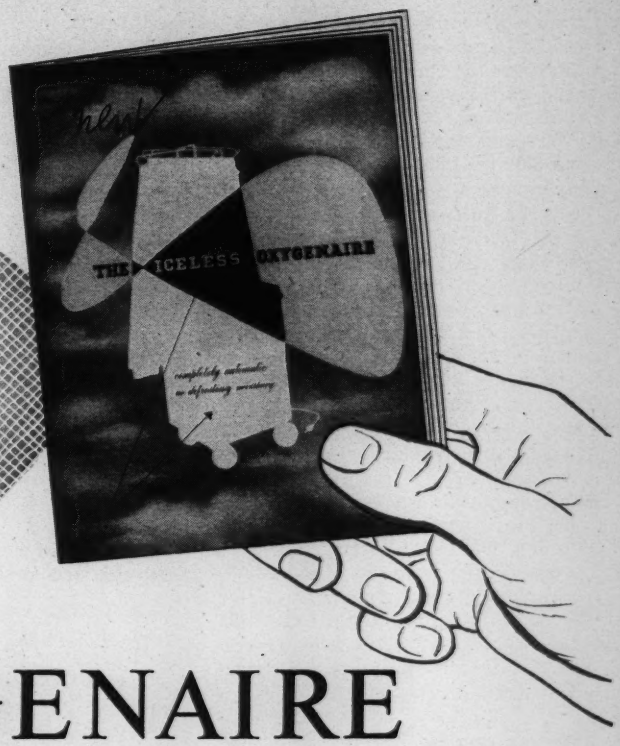
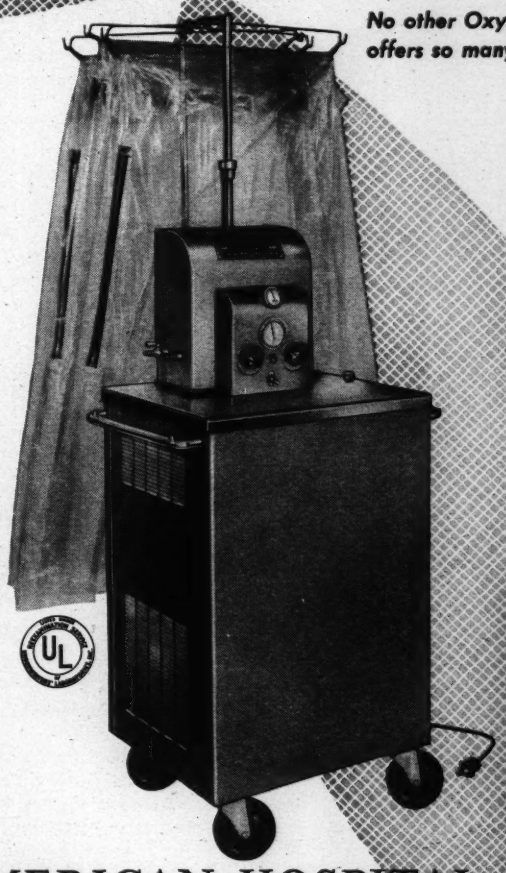


No other Oxygen Therapy Equipment offers so many vital features and conveniences



- There are several basic things to look for in selecting oxygen therapy equipment. Dependability, obviously. Simplicity of operation certainly ranks high. So, too, does ease of maintenance.
- This brochure which we'd like to send you, shows quite specifically how and why the ICELESS OXYGENAIRE provides oxygen therapy in its simplest, most dependable form. It is *completely* automatic. Temperature and humidity are *automatically* controlled. Air is *automatically* filtered. Condensate is *automatically* evaporated. No defrosting—no "freeze-ups" to endanger sustained operation.

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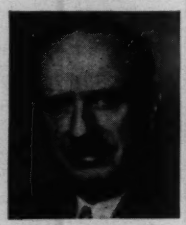
time will come—if it has not already passed—when the value of the nursing service given by the student nurse will be much less than the cost of her education. The difference will have to be met by the sick patient or by some outside agency.

It is quite proper for government funds to be made available to carry the financial educational burden for nurses, who will be caring for patients not only in the hospital but also in the many governmental, community and industrial agencies that now freely reap the benefits of hospital nursing education programs.

Any governmental program, however, should be planned to provide a maximum of flexibility at the local level, and it should be guided by a policy board that is truly representative of the public and agencies working with nurses, as well as nurse educators.—DR. ALBERT W. SNOKE, *director, Grace-New Haven Community Hospital, New Haven, Conn.*

Nurses can be recruited without federal aid

EVERYONE, IT SEEMS, is in favor of strict economy in federal spending, except those who might benefit by one of the "handouts." Excessive federal spending should be cause for alarm on the part of everyone. If we are ever to start promoting frugality in Washington, we should start now, although now may be too late. That is my prime reason for being against federal aid to nursing education. The second reason is that we get back too small a part of any dollar routed through Washington.



MR. HAYES

The Bolton Bill, as now written, would give $150 per year for each student nurse to "approved" diploma schools. That would pay for one meal each day for a student nurse. If it paid for four meals, I still would oppose the bill.

We have done well in recruitment without federal aid. We will continue to do so. The United Defense Fund (through community chests) has promised help to cover cash costs. I am sure the Advertising Council will continue its most valuable work.

The Bolton Bill provides for scholarships to nurses, but I am certain these scholarships would be more sought after if they were provided by local communities or by the states.

I do not feel that the Bolton Bill will bring us any more students. We can recruit the nurses in our local areas and states without federal aid. It might be well for us to show the public that hospitals are not selfishly interested; that they do not want our national debt or our taxes increased, and that we are willing to work out this problem as we have worked out so many others—on a community or state basis.—JOHN H. HAYES, *superintendent, Lenox Hill Hospital, New York City.*

Federal aid needed if more nurses are to be trained

THE NEED FOR additional nurses and auxiliary nursing personnel is great and is acknowledged throughout the country. The expansion of hospital facilities to meet civilian needs, the mobilization of industry to meet the present emergency, and the building of veterans hospitals has meant that nurses are required in greater numbers than ever before.

MISS CURTIS

The intensified nurse recruitment campaign sponsored by the nursing organizations and the American Hospital Association is producing encouraging results but not nearly enough nurses to meet the needs. The economic factor is the primary reason why many young women do not enter schools of nursing and why schools who have enrolled their quota cannot expand their facilities to accept more students.

The voluntary hospitals and the patients they serve have largely borne the cost of nursing education. The federal government, in the Public Health Service, the Veterans Administration and the armed forces, uses a large number of our nurses and must use more in the expanding civilian defense program, thereby taking nurses away from the voluntary hospitals and decreasing the supply for our civilian patients. Yet there is at present little if any contribution by the government to the cost of nursing education. It seems to me only just that the government should help meet this cost.

Schools of nursing must be expanded to educate more nurses, and facilities for training auxiliary nursing personnel in hospitals must be increased if the supply is to be at all adequate. There must also be provision for the education of instructors, nurse administrators and supervisors. The financial burden of this education will be great and the government should assume its share.

Financial aid is necessary if schools of nursing are to expand to educate more nurses and if young women are to be attracted to the nursing profession and to training programs in the care of the sick. Schools of nursing—collegiate, diploma or practical nurse schools—should know their costs, adjust tuition accordingly and receive scholarship aid for students when necessary to underwrite that cost.

I believe this can be done best and most rapidly through federal aid and support. This also is the majority opinion of the House of Delegates of the American Hospital Association. — MIRIAM CURTIS, R.N., *director, Syracuse (N.Y.) Memorial Hospital.*

Federal aid is not only desirable: It is a duty

WE ALL AGREE that our whole economy, of necessity, is changed in an emergency situation as brought about by war, or, as in the situation with which we are faced today, the necessary preparation in the current threat of war which we hope to avert.

MSGR. HEALY

Under such an emergency economy, it seems to me that federal aid is not only desirable but a duty of the government in order to meet the unusual demand for nurses and relieve the critical nurse shortage which already exists.

Certainly, the thesis that a critical shortage of nurses existed before the current emergency is accepted by all. Furthermore, I believe it is generally conceded that this shortage, having been with us before the emergency situation and now becoming more critical,

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1. LESS FRICTION between plunger and barrel.

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Less friction, less erosion, and less breakage mean longer life . . . and lower cost-in-use.

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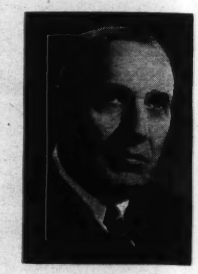
will without doubt continue for many years after the emergency passes into history.

The above, together with the fact that training schools of today are preparing nurses for all segments of our society, such as industry and government, without any direct financial assistance from these sources, points to the justice and equity of federal aid (assistance from *all* people through our government) to these schools.

We definitely are being shortsighted when we sponsor a platform that this aid "should be on an emergency basis and temporary in character," because: (1) The shortage has existed for some time; (2) the emergency made an already existing shortage more critical, and (3) the prognosis that the shortage will continue for some years is sound.—RT. REV. MSGR. JOHN J. HEALY, *director of hospitals, Diocese of Little Rock, Ark.*

Government hires nurses, should help train them

CONCERN HAS BEEN expressed that government aid automatically brings government control or interference. It has been said that the solution to the problem should be found locally. It also has been said that many other classes or businesses find themselves short of personnel and are not asking the government to bail them out.



MR. SWANSON

A fundamental factor in the nurse situation that is not present in some of these other instances is the acute shortage of nurses, both graduate and student. This means that nursing care may be inadequate in some instances or that beds may be closed for want of nurses. Such loss of beds is tragic in a time of insatiable demand for hospital accommodations.

Many hospital administrators have indicated that they feel that aid or subsidy from some source is essential if hospitals are to continue to give adequate care to the sick and injured. The appeal to the government for federal aid for nursing education is justified by the fact that the hospitals have been, for the most part, the only training place for nurses. It is apparent that many of the graduate nurses are absorbed by many employers other than hospitals, who have had to carry the financial burden of the complete training program.

One of the largest users of nursing personnel is the federal government. It needs nurses for its many government operated hospital facilities and for the armed services. The government has not assisted financially in the training of these nurses and it surely is not unreasonable to ask for some help. If some such assistance is provided, the money might well be used not only for the present nursing program but also to explore and experiment with new developments in nursing education that might provide a solution to the problem by making nursing more attractive as a

(Continued on page 156)

You GET THE ANSWER— She GETS HER REST

Nurse-Saver* Permits Instant Two-Way Communication between Switchboard and Individual Rooms of Nurses' Home

Now you can have two-way communication between lobby and individual rooms in your nurses' home at a considerable saving over a standard telephone system. With Nurse-Saver, business or personal messages can be delivered, questions can be answered without the nurse leaving her room. Time is saved for everyone, with minimum interruption to the nurse's privacy during her off hours.

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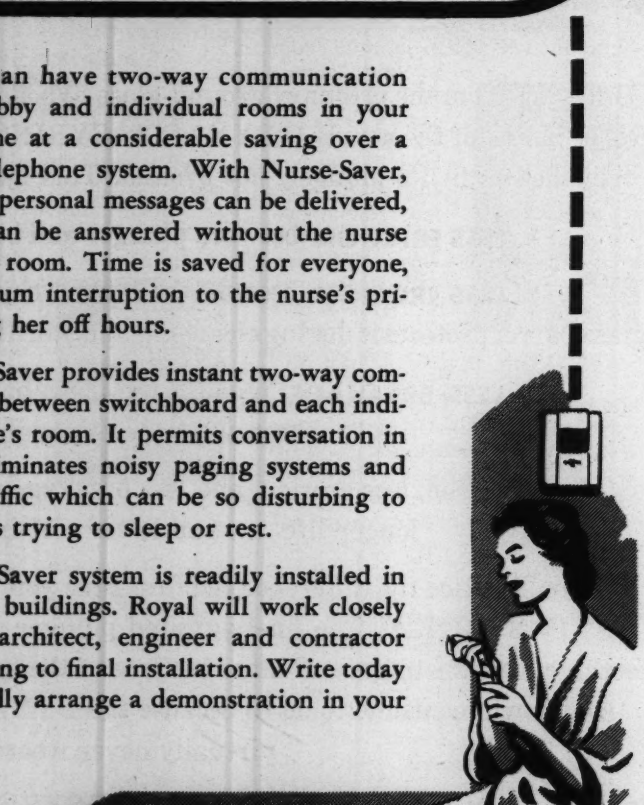
*T. M. Reg.



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HOSPITALS—DOCTORS—BLUE CROSS

A three-way partnership to help control COSTS of PREPAID CARE

JAMES E. STUART

EXPERIENCED INSURANCE people have always maintained that Blue Cross is actuarially unsound. They say it offers the subscriber an open-ended contract without money limitations and with all controls being exercised by persons or groups whose immediate interests might be promoted by abuses of its contract provisions. To say that the Blue Cross contract is open-ended is a gross understatement. It is, in fact, also open at both sides.

In Cincinnati, our approach to the problem of preventing abuses of the contract has been one of developing controls through doctors and hospitals. We have made these groups an integral part of the Blue Cross program with a definite responsibility for policy making.

The extent, amount and cost of hospital service which Blue Cross guarantees to provide its subscribers are not determined in any substantial degree by Blue Cross itself, but rather by the doctor, the hospital, and to some extent the subscriber himself. The doctor decides who shall be hospitalized, when and where he is to be admitted, how long he will stay in the hospital, what services and how much of these services will be provided. The patient may influence the doctor in any of these determinations.

The hospital decides the charge for each unit of service or commodity provided. Together, doctors and hospitals completely control Blue Cross financial experience. The only function of Blue Cross is paying the bill.

The impossibility of Blue Cross plans directly controlling their own financial experience is the very factor which made experts predict an untimely demise for Blue Cross. They felt that without some direct controls bankruptcy was certain. So far, the experts have been wrong.

In an expanding economy, with an upward trend in all prices, Blue Cross has been able to make successive rate increases to its subscribers and at the same time increase membership. But this cannot continue indefinitely. There is a point of diminishing returns which in some areas may have been reached already.

The first step in our new control program was the establishment of the Hospital Advisory Council—the keystone of the Cincinnati Blue Cross hospital relations program. This council is made up of the administrators of all participating hospitals. The chairman and vice chairman of the council are *ex-officio* members of the Blue Cross board of trustees. Through this representation, the operating heads of hospitals are assured of a direct voice in the Blue Cross policy making.

The Hospital Advisory Council has been operating since July 1939—two months before the Cincinnati Blue Cross plan enrolled its first group.

ROLE OF ADVISORY COUNCIL

The Hospital Advisory Council has a number of functions. First, it represents the participating hospitals in the program and policy making of the Cincinnati Blue Cross plan. No change affecting hospitals has ever been made in the Blue Cross contract or in the Blue Cross program without first securing the recommendations of the Hospital Advisory Council.

Second, the council is a self-disciplining body. All problems with hospitals, individually or collectively, are referred to this group. The Blue Cross plan is never put in the position of telling hospitals how they should run their institutions. All decisions are made by the hospitals themselves.

Third, the council is a valuable source of ideas and advice. An example is the "three day rule," suggested by the Hospital Advisory Council to meet the problem created by doctors who prescribed expensive medications to be given routinely, and then forgot to cancel the order when the drug was no longer needed. The council suggested, and put into effect, a rule that all such prescriptions must be renewed every three days or the drugs would be automatically dis-

Mr. Stuart is executive vice president of the Hospital Care Corporation, the Blue Cross plan of southwestern Ohio. This article was adapted from a paper presented during the American Hospital Association annual convention, St. Louis, September 1951.

continued. A uniform mark-up on drugs was established in the same manner. These and other self-initiated control measures have resulted in substantial savings for Blue Cross.

Fourth, the council gives us our most effective method of acquainting hospital administrators with Blue Cross problems, thereby further developing a sense of responsibility toward Blue Cross.

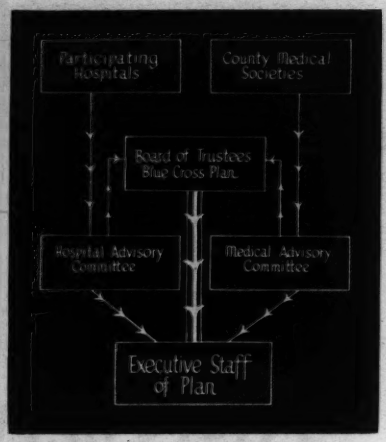
Another important part of the Cincinnati Blue Cross plan's hospital relations program is a statement issued monthly showing comparative costs in participating hospitals. The statement performs a valuable function by complimenting the hospitals whose costs are low and calling attention to those whose costs are high.

Probably one of the most significant contributions toward building friendly relationships with member hospitals was made by a two-year program (1946-1948) conducted by the Cincinnati Blue Cross plan to educate the public to accept the necessarily higher cost of hospital service.

This was a comprehensive program, which included a considerable amount of advertising paid for in full by the Cincinnati plan, extensive newspaper and radio publicity, talks by hospital administrators before various civic organizations, and educational meetings for the public at hospitals.

The results of this program were beneficial to Blue Cross as well as to hospitals. By understanding the need for hospitals to increase their charges to patients, the public was far more willing to accept the increases in Blue Cross membership fees.

The Cincinnati Blue Cross program for education of the medical profession is a fairly recent one compared with the hospital relations program. The program for doctors began late in 1947 and grew out of a series of meetings held with the medical staffs of member hospitals to acquaint them with their role in the Blue Cross plan. From these meetings came the conviction that the future of Blue Cross was in the hands of the doctors and that a continuing program of education of the medical profession was necessary, not only



as a method of controlling the cost and usage of hospital service, but also to make doctors realize how important Blue Cross is to them.

To aid the educational program, we began printing *Blue Cross Briefs,* a newsletter type of publication which has been mailed each month since October 1948 to all southwestern Ohio members of the Ohio State Medical Association.

At first the publication went out over the signature of the Cincinnati Blue Cross plan. The copy for each issue was checked and approved by the executive officers of the Ohio State Medical Association, which provided names of doctors for a mailing list.

In March 1949, the Blue Cross Medical Advisory Committee was organized to represent the medical profession in the program and policy making of the Cincinnati Blue Cross plan. Beginning in June 1949, *Blue Cross Briefs* was published over the signature of the new committee.

We have learned that there is a vast difference between what we, as Blue Cross people, can say to doctors, and what the Medical Advisory Committee can say. With the committee, it is a case of doctors talking to doctors, not Blue Cross telling the doctors something they might consider advice on how to practice medicine.

Through *Blue Cross Briefs,* the doctors in southwestern Ohio have been told that the success of Blue Cross has been and always will be in the hands of the medical profession—that doctors can make or break Blue Cross. The Medical Advisory Committee has explained to them how Blue Cross experience is determined by the medical profession, since it is the doctor who decides the amount of laboratory work, x-rays and medications to be prescribed in each case. The committee has pointed out that the medical profession and Blue Cross are in the same boat, and that the steering is in the hands of the doctor.

The committee has explained many times and in many different ways that voluntary health service plans like Blue Cross and Blue Shield are the last bulwarks remaining between the medical profession and socialized medicine, and that bankrupting Blue Cross is the surest way of bringing about a system of government medicine.

Specific problems have been taken up with the profession. When hospital bills continued to increase in amount during a period when hospital charges remained stable, doctors were told that they were responsible, that they had been prescribing more drugs, more laboratory work, and more x-rays than ever before, and that they were keeping their patients in the hospital longer than during the preceding years.

The principal theme of *Blue Cross Briefs* is medical economics in the broadest sense. The newsletter is also used to announce open membership periods to the medical profession, summarize annual reports and give other information of interest to physicians.

Another item which has done much to cement our friendship with the medical profession is a doctor's office plaque. This plaque explains to Blue Cross members who may be consulting the doctor that they should not request unnecessary hospitalization, and outlines the services not covered by Blue Cross. In this manner, the doctor has the official support of Blue Cross when he must tell a member that a hospital admission solely for diagnostic study or physical check-up is not covered.

INFLUENTIAL MEDICAL GROUP

The organization of the Medical Advisory Committee is similar to that of the Hospital Advisory

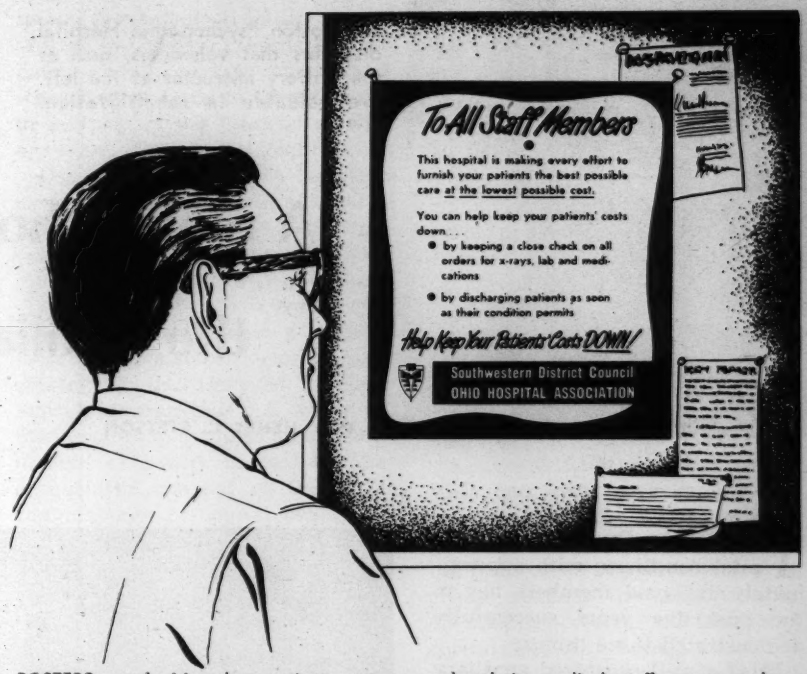
Council. Its membership is made up of representatives of the urban medical societies. For the most part, these representatives are county society presidents, past presidents or presidents-elect. The chairman and secretary of the Medical Advisory Committee serve as *ex-officio* members of the Blue Cross board of trustees.

Members of the Medical Advisory Committee are influential men within the medical profession. They not only represent the physician's viewpoint, but they also serve as successful Blue Cross missionaries within their group. In the hospitals, at medical society meetings and other professional gatherings, they are prepared to promote Blue Cross and clear up misunderstandings about its program.

THE INDIRECT APPROACH

Along with the direct approach to the medical profession, another program of doctor-education has been conducted through and by the hospitals. Member hospitals have been furnished with a series of posters and chart stickers whose theme is "help keep your *patients'* costs down."

The posters are placed in medical staff rooms and on staff bulletin boards. The chart stickers are used selectively—only on charts of patients where the sticker is appropriate in that particular instance.


To All Staff Members
This hospital is making every effort to furnish your patients the best possible care at the lowest possible cost.
You can help keep your patients' costs down...
● by keeping a close check on all orders for x-rays, lab and medications
● by discharging patients as soon as their condition permits
Help Keep Your Patients' Costs DOWN!
Southwestern District Council
OHIO HOSPITAL ASSOCIATION

POSTERS emphasizing low patient costs are placed in medical staff rooms and on staff bulletin boards. The posters, published over the signature of the Southwestern District Council of the Ohio Hospital Association, contain no mention of Blue Cross.

Copy for both posters and chart stickers is approved by the Hospital Advisory Council before publication. The posters now are being published over the signature of the Southwestern District Council of the Ohio Hospital Association.

Largely because of this program, the Cincinnati Blue Cross plan has not made a general increase in membership fees for two and one-half years. Its last general fee increase became effective on March 1, 1949.

Even more significant, during 1950 the Cincinnati Blue Cross plan added more to its reserves than in any previous year—nearly 50 per cent more than in 1949, the year of the last general fee increase.

Specifically, $583,000 was placed in reserve during 1949, while $750,000 was added to reserves in 1950. Without a program of hospital-physician relations in operation, the entire $750,000 added to reserves last year might have been wiped out by increased payments to hospitals.

Our experience during the last 11 years with hospitals and during the last two and one-half years with doctors has demonstrated, we believe, that a Blue Cross plan can exercise some control over its financial experience by taking doctors and hospitals into partnership, by giving them a real part in policy making, by making them an integral part of this vital community effort in which they have such a tremendous stake, as well as such a great responsibility.

Blue Cross MEMBERS
Your Blue Cross Hospital Care membership covers necessary hospitalization. It does not cover services that can be given at home, in a doctor's office or in the out-patient department of a hospital (except emergency out-patient service received in a hospital within 24 hours after an accident.)
Please do not ask your doctor to send you to the hospital for services which do not require hospitalization . . . hospital admission for physical check-up or for observation only is not covered by Blue Cross Hospital Care.
When your doctor decides that bed-care and treatment in a hospital is necessary, you will of course be entitled to the full benefits of Blue Cross membership.
HOSPITAL CARE CORPORATION
CINCINNATI DAYTON SPRINGFIELD

PLAQUES such as the one above are hung in doctors' offices to remind patients that they should not ask for hospitalization unless it is necessary.

The Boston Psychopathic Hospital discovers that volunteers, such as the pottery instructor at the left, are valuable in rehabilitation.

A mental hospital enlists the auxiliary volunteer

MRS. HENRY C. STETSON

THE BOSTON Psychopathic Hospital Auxiliary, with approximately 360 paid members has in the past five years successfully demonstrated three things:

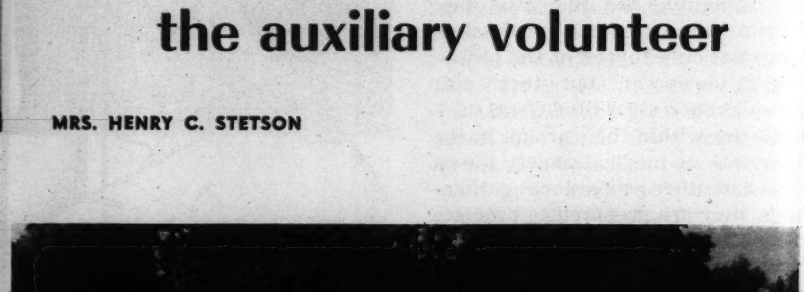
THAT a well organized auxiliary in close touch with its administrator can be of great service to the hospital, patients and staff of a mental hospital.

THAT volunteers in a mental hospital can be, among other things, a valuable part of the hospital treatment team.

THAT both informed auxiliary members and active volunteers can serve to interpret the problems and needs of mental patients to the community.

The Boston Psychopathic Hospital serves only acutely ill patients. As such, it uses all the facilities that a general hospital has—laboratory, x-ray, operating room, an expanded social service, and a highly accented program of occupational therapy. On the financial side, costs at the hospital are comparable to those at the Massachusetts General Hospital.

In comparatively recent years, great strides in the field of mental health have helped to remove the medieval atmosphere of taboo and silence surrounding the unfortunate mental patient. "Insanity" is not a medical term but a completely legal one. In a medical sense, patients fall into a number of diagnostic groups, all differing as to symptoms, course of illness, treatment and prognosis. The majority of the Boston Psychopathic Hospital patients are acute patients and can look forward to recovery within a matter of a few weeks or months.



AUXILIARY volunteers and patients enjoy outdoor sports at the Boston Psychopathic Hospital where a program of "activity therapy" is designed to speed a patient's recovery.

If treatment should prove unsuccessful, patients then are transferred to the chronic wards of the large state hospitals. A much higher percentage of cures accomplished in far shorter time is slowly changing the old mental hospital atmosphere of depression and despair to one of hope and constructive activity.

Primarily this is due to five factors: (1) An adequate ratio between the number of patients and the number of attending doctors; (2) prompt treatment at the onset of illness; (3) up-to-date medical techniques; (4) pleasant, restful surroundings devoid of suppression and regimentation, and (5) volunteer aid to promote the hospital program of "activity therapy."

The volunteers who share their interests and talents with the patients are recruited from several sources. From the Red Cross come the Gray Ladies, and from men's and women's colleges come advanced students in psychiatry, psychology, education, the social sciences, occupational therapy and physical therapy. Volunteers come from theological schools, the Boston Volunteer Service Bureau, the Boston Junior League, The Boston Junior Chamber of Commerce, ex-patients, and the auxiliary.

They are oriented by (1) an interview with the hospital assistant superintendent, Dr. Robert W. Hyde, or the auxiliary chairman of volunteers; (2) by a pamphlet drawn up by the assistant superintendent, answering typical ques-

Mrs. Stetson is chairman of public relations, Boston Psychopathic Hospital Auxiliary.

tions of volunteers; (3) by "on-the-job" work with patients under staff supervision; (4) and by the opportunity of attending staff conferences.

Volunteers may serve as typists in the research or social service departments, or they may be used in the occupational therapy, physiotherapy, or nursing departments. In the latter department, they assist in feeding and reassuring patients after insulin or electric shock therapy. According to the records of the occupational therapy department, volunteer workers put in more than 7,300 hours of work in 1950.

The hospital, with its 117 beds, serves not only the metropolitan Boston area but also the entire state of Massachusetts. Students in medicine, psychiatry, nursing, psychology, psychiatric social work, occupational therapy, physiotherapy, and chaplaincy receive both experience and instruction here. There is, therefore, a necessarily higher proportion of doctors, students and other personnel per patient at the hospital than at any of the other state hospitals. For this reason and because of the hospital's comparatively small size, problems in mental health are more easily solved and new ideas and techniques more easily introduced. A patient-edited news letter, a patient government structure representing the different wards, an ex-patients' club, and an open ward whose patients are privileged to go in and out of the hospital at will are some of the newer features.

One of the hospital's greatest contributions to the field of mental health is its highly active and successful auxiliary. This was formally organized in 1945 at the request of Dr. Harry C. Solomon, the present medical director. Dr. Solomon, who is also professor of psychiatry at the Harvard Medical School, encouraged the wives of staff doctors to serve as its original nucleus or board. Backed by the enthusiastic consent of the state commissioner of mental health, as well as by the hospital trustees, the auxiliary expanded to include first a group of people already interested in mental health and then an even larger group of lay people.

OBJECTIVES OF AUXILIARY

Its objectives are as follows: (1) To promote the welfare of the hospital, patients and staff; (2) to increase the hospital volunteer corps, and (3) to increase public understanding of mental illness. A board of nine chairmen meeting once a month, together with a group of volunteers, constantly worked to promote these objectives. Funds stem not only from gifts and the $2 membership dues, but also from the sale of "pop" concert tickets and a dance backed by a long list of sponsors.

The Boston Psychopathic Hospital believes strongly in the therapeutic value of an esthetic physical environment, together with a program of "activity therapy." The auxiliary therefore devotes most of its funds to helping the hospital carry out these two treatment policies. It seeks to provide the hospital with things over and above what a state budget can possibly provide, things which, however, materially aid in the recovery of the patients. Staff members, volunteers and even patients unite in painting the walls, while the auxiliary seeks to provide items ranging from cards to pianos. A sewing group assumes the responsibility of making colorful curtains and spreads and of re-upholstering furniture. These activities help to produce the relaxed and cheerful environment which best promotes the security of the patients as well as the morale of the staff and personnel.

The auxiliary has aided the hospital "activity therapy" program through the purchase of Sunday newspapers for all the wards, beauty parlor supplies, handicraft materials, a set of attractive dishes for the women's convalescent ward, and two pottery kilns for use in an auxiliary conducted pottery class. A teacher has been provided to instruct patients in ballroom dancing, an activity which tends to restore social poise and confidence. Holiday parties, with refreshments, and evening entertainment have helped relieve monotony at the end of the day.

The auxiliary, through its news letter, keeps not only its old members and volunteers posted as to hospital and auxiliary activities, but also the superintendents of all Massachusetts state mental institutions. Partially because of the contributions of the Boston Psychopathic Hospital Auxiliary and its volunteers, at least four of the big state institutions have successfully opened their doors to the much needed help and interest of outside volunteers.

Since a well informed membership can be a great asset in the field

DURING the summer months, the members of the hospital auxiliary lend their cars so that, bi-weekly, 30 to 75 patients can travel to the seashore to swim, sunbathe or picnic.

of mental health publicity, the auxiliary has also sponsored small educational meetings in private homes. At these meetings, 13 of which have been held to date, Dr. Solomon has discussed the general problems and needs of mental hospitals and their patients, and the auxiliary program has been explained. Knowledge first of *what needs to be done* and then of *what is being done* leads often to an active desire to join and help either inside or outside the hospital. It is not surprising that auxiliary membership has grown from 97 members in 1948 to 360 at the present date.

One indication of progress is in the increasingly successful use of volunteers working directly with the patients. The very presence of volunteers in such a hospital tends to increase that sense of security which mental patients lack. Unable by reason of their particular childhood experiences or training to cope with the problems of the world of reality, mental patients are forced to draw back into themselves where they live in a compensatory, imaginary world.

To induce them to return to the world of reality, an atmosphere of kindliness, friendliness, and human warmth is necessary. Volunteers with human interests and a well rounded personality can do much to help badly understaffed mental institutions provide such an atmosphere. The very fact that nonsalaried outsiders are interested in a patient's behalf of itself tends to make him feel less lonely, isolated and withdrawn. He begins, with the help of this new human contact, the task of again learning to relate himself to others; he begins to feel he has a place in human society. He emerges first under guidance, then, as he gradually gains in confidence, he goes forward on his own.

It is at this critical point in the patient's re-education that volunteers make a second contribution toward the cure of the patient. They help through one or more activities to bridge the gap between the world of phantasy from which the patient is just emerging and the world of reality he once feared. A better adjustment must be made this second time if the patient is to recover his mental health. The hospital program of "activity therapy," planned to further this end, includes occupational therapy, physical exercise, and recreation such as games, music, dances, holiday parties and dramatics. Volunteers with one or more of these skills or interests take an active part in encouraging patient participation.

As mental patients are largely ambulatory in contrast with those with physical disabilities, volunteers help fill the time left over each day after medical treatment. They instruct patients in arts and crafts, music appreciation, nature study, or garden projects and assist the staff in accompanying patients on trips to concerts, movies, art museums, plays, or football games. Every other week during the summer from 30 to 75 patients go to the seashore to swim, sunbathe, and cook frankfurters.

Whatever the medium involved, the presence of the volunteer is of untold value in bringing about patient participation. Encouraged by a volunteer's friendly advances and constant reassurances, a patient is slowly encouraged to live again through whatever of these outlets he finds most appealing to the various facets of his personality.

More births in hospitals

THE PROPORTION of births that occur in hospitals has been rising for several years, and with this increase has come a continuous decrease in the infant and maternal mortality rates in the United States. Statistics illustrating this development of the past 10 years, which show also the amazing increase in the number of births attended by physicians both in and out of hospitals, are in a new study titled "Births by Person in Attendance: United States, Each Division and State, 1949" released last summer by the Public Health Service's National Office of Vital Statistics.

Of all registered live births in 1949, 86.7 per cent occurred in hospitals; 8.1 per cent were attended by physicians not in hospitals, and 5.1 per cent were attended by a midwife or other nonspecified person. (Fig. 1.)

In the nonwhite group, the percentage of births occurring in hospitals is not as high as for the white group.

In rural areas the percentage of births in hospitals has increased tremendously. (Fig. 2.)

Fig. 1

LIVE BIRTHS BY PERSON IN ATTENDANCE: UNITED STATES, 1935-49

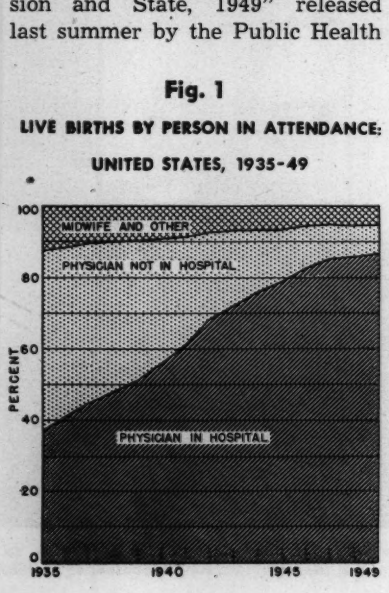
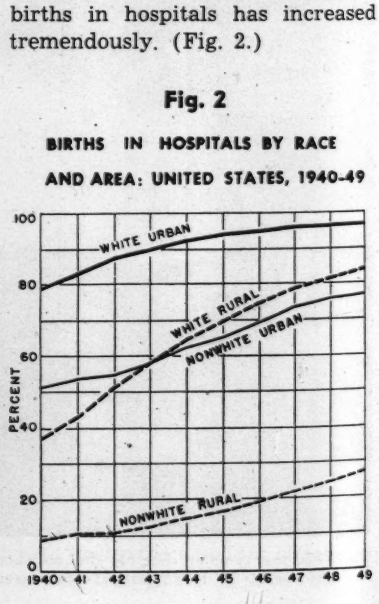


Fig. 2

BIRTHS IN HOSPITALS BY RACE AND AREA: UNITED STATES, 1940-49



A COMMUNITY SURVEY

More pediatric beds mean low use and high costs

GEORGE W. BROOKS AND RAY E. BROWN

INTEREST IN the construction of additional hospital facilities sometimes has disclosed that communities are uncertain about the need for particular bed services and the availability of existing services.

Such a problem was posed to the health reviewing committee of the Community Fund of Chicago when a highly qualified, medium-sized hospital announced its intention of adding pediatric beds. At about the same time that the building plans were announced the committee had expressed its concern over low occupancy rates in several large pediatric units and the requests for support of newly expanded, highly specialized services in separate institutions for children.

At the request of the Community Fund, the Health Division of the Welfare Council of Metropolitan Chicago appointed a committee to assemble information on how the available hospital beds for children in the area are being utilized and the factors that determine utilization. A committee on hospital pediatric bed facilities, composed of pediatricians, hospital administrators, hospital planning experts and interested lay hospital board members, was appointed.

It has been fairly well accepted that, in general, children's beds are not utilized as fully as are adult beds. Preliminary data proved the assumption of low utilization of pediatric beds to be correct in the Chicago-Cook County area.

The task of the committee was then determined to be one of ascertaining the cause or causes of the low utilization of pediatric beds in an area and a period when adult hospital facilities are overcrowded. In other words, it was necessary to examine those factors that might have an influence on pediatric admissions and would not be operative to a great extent on adult admissions. These factors were admission policies, such as those relating to nature of medical condition; financial ability to pay for care; physical arrangements of pediatric units; policies of the hospital in regard to separation of children on the basis of age, sex and medical condition; hospital teaching requirements; outpatient pediatric services, and the nature of medical staff privileges. It was also agreed that the question of a fundamental change in the pattern of illness and medical care of children would have to be considered.

The inquiry made by the committee covered the Cook County area and was limited to hospitals with organized pediatric units of 10 beds or more which serve only children under 15 years of age. Well-baby nurseries were excluded, as were hospitals restricting admissions to patients with contagious diseases, venereal disease, tuberculosis and mental illnesses. Through personal visits it was possible to obtain information on experience in the year 1949 from 27 pediatric units.

FINDINGS

1. In general, there is a significant number of unused pediatric beds in hospitals of the Cook County area as compared with what is considered good utilization of adult beds. This is true even after allowances are made for the lower occupancy percentages usually found in smaller units. Hospitals representing more than half the beds surveyed reported occupancy rates for 1949 of less than 78 per cent, and those representing more than one-third of the beds had occupancy rates of less than 70 per cent.

2. Pediatric bed occupancy is not materially influenced by intake policies relating to ability to pay for care. No hospital reported that securing funds for "free" care for pediatrics was a major problem.

3. In general, pediatric bed occupancy is not materially affected by intake policies as to race. With only a few exceptions, the hospitals of the Cook County area with organized pediatric bed units will admit Negro children to these units. In most cases there is no segregation of the children within the unit.

4. With the exception of the three largest pediatric units, the majority of the pediatric units are on one floor, easily supervised, and flexible in their physical arrangements. They do not suffer lowered occupancy rates because of rigidities resulting from physical division of the units on the basis of age, sex or medical condition, or division of services according to ability to pay. Most hospitals saw the demand for services as divided into two age groups—infants and children—with the heaviest demand for hospitalization of infants. These hospitals generally were large enough and flexible enough to be able to provide the particular service as needed.

The size of the patient room is affected by this group of factors. Rooms with multiple beds are inflexible when children are divided by sex and age. The same difficulty occurs in the need for isolation of patients. A children's unit made up entirely of single bed units would be ideal as regards the problem of admission flexibility.

5. The maintenance of outpatient pediatric services does not

Mr. Brooks is associate executive secretary, Health Division, Welfare Council of Metropolitan Chicago. Mr. Brown is superintendent of the University of Chicago Clinics. Mr. Brooks was secretary and Mr. Brown was chairman of the committee that made this survey.

result in high occupancy levels, nor does it reduce fluctuation in occupancy in these units as compared with hospitals without such services. It is suspected, however, that outpatient pediatric services tend to keep occupancy levels higher in hospitals maintaining them than would be possible otherwise.

6. In the great majority of hospitals, staff physicians are permitted to attend private patients in the pediatric units, while service cases are assigned to a pediatrician. A few hospitals restrict staff privileges to qualified pediatricians. These policies have little over-all effect on pediatric bed occupancy rates.

A number of administrators believed that if their staff privileges could be extended to more doctors more children could be taken care of. They emphasized that such privileges should be accorded to more general practitioners. This assumption would be valid only if children are being denied hospitalization because their doctors do not have hospital privileges and will not refer patients to doctors who have such privileges. If the assumption is valid, it touches a factor that significantly affects pediatric bed occupancy rates.

7. Teaching considerations for students, nurses, interns, residents and others markedly influenced the provision of pediatric bed facilities. Since most pediatric units in the Chicago-Cook County area are well established, no special effort seems necessary to keep up the level of occupancy for this purpose.

Linked to the teaching of student nurses was the service element. In providing a pediatric unit large enough to meet the needs of student nurses the desire has been to keep the services of students within the hospital during the time that otherwise would be required for affiliation for pediatric nursing. The impression was received that if occupancy rates fell below teaching requirements, especially for student nurses and residents in pediatrics, strenuous efforts would be made to increase that level.

8. Pediatric bed occupancy is not materially influenced by intake policies relating to the nature of medical condition. Most of the hospitals do not accept children with contagious diseases. Beds for such patients are provided in the pediatric units of the Municipal Contagious Hospital and the Cook County Contagious Hospital.

9. Many children's diseases formerly requiring hospitalization now are controlled almost entirely. Because of medical advances the care of children is becoming increasingly a matter of home care and outpatient services. For these reasons there is a longterm downward trend in the utilization of pediatric beds.

CALL FOR COORDINATION

There is obvious need for coordinated planning in the construction and utilization of pediatric bed facilities. Medical schools, hospitals, medical staffs, nursing schools, and others interested in the provision of pediatric bed facilities extensive enough for teaching and service requirements should be encouraged to devise ways and means of utilizing existing services instead of adding new facilities. Hospitals considering expansion in pediatrics on the basis of requests for medical staff privileges should be encouraged to examine total existing services in the community before planning new facilities. The dynamics of modern medicine make this doubly necessary.

It is especially important that the provision of additional beds in the form of separate children's hospitals should not be encouraged. While it is recognized that such institutions frequently offer hospital care of high quality, this study reveals that such specialization results in rigidity in the use of pediatric beds. It is also recognized that beds in separate institutions are not as readily convertible to other uses when there is a reduction in the need for specialized service.

Professional care for flowers

FLOWERS ARE as much a part of the hospital as white linens and rubber-soled shoes. They should be planned for accordingly.

At New Britain (Conn.) General Hospital, we have worked out an arrangement with the local florists' association to give flowers the good care and rapid delivery to patient rooms which both patients and purchasers desire.

The florists' association hires part-time help to work in the hospital's flower room four days each week. The worker arrives at 1:30 P.M., after most deliveries have been made. She records deliveries, secures room numbers and sorts deliveries by floor. On a flower delivery cart, floral arrangements are made, one floor at a time. A special chemical is used in the water to prolong the life of flowers and make new water unnecessary.

Flowers are delivered to the floors when arrangements are finished. In her remaining time, the worker empties out old flowers and returns vases to the central flower room. Two vases are left at each nurses station for flowers brought in directly by visitors.

Salary and incidental costs of the program are paid by florist association members on the basis of a fixed levy per delivery to the hospital by each member.

Benefits from this system for handling flowers are many. Nurses and other hospital employees are relieved of routine duties. With one central flower room, the flower room space on each floor has been returned to nursing units. Finally, speedier deliveries and more attractive arrangements are possible with the flower handling system. —*Submitted by* ALEXANDER MCALILEY, *assistant managing director of New Britain (Conn.) General Hospital, as an entry in the "What's an Idea Worth?" contest.*

The control of hospital business forms

MYRON A. KLAPPER, B.A., M.B.A.

BUSINESS FORMS have a very real function in hospitals. Properly used, forms make possible the simplification of procedures. Properly used, they provide a concise method of recording essential historical data. Properly used, they serve as a medium for transmission of instructions. In brief, properly used, they save effort and time —thousands of hours of staff time —which can be readily translated into dollars.

But there is also a potential danger in the use of forms, a negative aspect which is often overlooked. Forms may interfere with the professional services of the hospital, making difficult the care of patients. They may create costly red tape and confusion. They may contribute to bad public relations. They may and often do waste instead of save staff time. Instead of simplifying the performance of a job, they may make its completion more difficult. They may stand in the way of improving methods.

Think of hospitals purely in terms of the big business that they are. One would not think of cash transactions without vouchers, receipts, checks and cash accounts. Yet forms are also money: Dollar money, time money and space money. This money, ranging from thousands of dollars in the smaller hospitals to tens and hundreds of thousands in the larger hospitals, is often spent without adequate controls—sometimes even without knowledge of how it is being spent. An illustration is cited by William H. Leffingwell, late president of the National Office Management Association.

"In one office a certain record was carried on a sheet kept in a loose-leaf binder. The cost of keeping this record was $7,000 a year. The shape and size of the form were all right, and the binder was a standard one. The record was easy to use and in fact had been so simplified that to make an entry took but a matter of seconds. It seemed as though nothing could be improved. A little further study, however, showed that the information contained on this form was being independently gathered in another department; the study also showed that this loose-leaf record was referred to so seldom that it could be eliminated altogether, thereby saving the $7,000 a year."

Properly functioning forms control corrected this situation.

CENTRALIZED CONTROL

Hospital-wide coordination of forms control is essential to an effective forms control system. A form seldom is used exclusively within one department. Although it may originate and be completed at one point, its data often is used elsewhere in the organization.

The forms control system, no matter how well devised, can be only as good as the person administering it. He must, first of all, be able to gain and hold the cooperation of all employees. He should also be an expert salesman. He will see many possible improvements in forms and may have to convince department and service heads that one of their "pet" forms is useless, a waste of time and money. He should be familiar with office equipment and know good management practices. He should be a person who can gain the respect of the staff. And he must have the technical know-how of the design and control of office forms.

If a single person is to administer forms control, he might be the comptroller or director of the hospital, but it is doubtful if either is properly qualified. Even if they are, they have many other duties. A forms control committee advised by a trained forms control analyst could serve as the central authority. This committee might consist of a professional staff member, an administrative staff member and the purchasing agent.

SETTING UP A FORMS FILE

With centralized control established, the next step can be the creation of a forms file with a separate folder for each form. All information relating to the form as well as copies of the form should be in the file folder. This will include the type of paper, style of type, printing process, cost of printing, number and size of previous printings, economical order quantities, changes in the form and reasons, description of the procedure in which the form is used and a list of related forms.

All suggestions for changes should be placed in the file folder. Although they may not be important enough to warrant creation of a new form, it is a good practice to file them for future reference when the form is revised.

In organizations using few forms, the control authority may rely solely on memory for the relationship of one form to another. In a hospital using many forms a list of all related forms should be placed in the file folder. Then when a form is revised or discarded, the effect on all other forms concerned can be determined.

It may not be necessary to establish a complete file of data for every form. If an organization uses few forms a complete file folder system will defeat its own purpose by being cumbersome and expensive. Such an organization may find it more efficient to place only a copy of the form in the folder together with a specification card identifying the form and listing, for each time it was ordered, the vendor, date, purchase order number, quantity and the

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Mr. Klapper is director of the office management division of the New York Association for New Americans, Inc. This article is adapted from a paper delivered at the 1950 Seminar for Hospital Accountants and Business Office Personnel, sponsored by the United Hospital Fund and Greater New York Hospital Association.

price. As the number of forms in use increases, there are generally more complex procedures.

It is impractical to go through the complete file every time a form is changed or a new one requested. This can be avoided by filing the forms functionally, grouping those related to a particular activity or procedure. The division in such a file may be accounting, medical service, personnel and so forth. A functional file lends itself to easy reference.

FORMS CONTROL CHART

A forms control chart is another satisfactory type of reference. All the items of information contained on all forms are listed vertically. Across the top of the chart on the horizontal line are the name and number of each form in use. A check is made in the box corresponding to the information for each form. This chart graphically provides the data on each form and shows the forms on which a given piece of information is recorded.

Several charts must be used if there are many forms. In such instances, a functional grouping can be followed by charting within functions. The value of this technique is illustrated by the following case history. In a large organization using many hundreds of forms, there are three departments which collect cash. Previously, each department used a different receipt form. Although there was centralized responsibility for forms control, the forms control authority was unaware of this situation. When functional grouping and charting were put into effect, the duplication was discovered. The three forms were replaced by one. With chart control in effect, it is doubtful if this condition could have developed.

WORK SIMPLIFICATION

The hospital staff should be informed that all requests for new forms, for changes in forms, and for disposing of obsolete forms must be forwarded to the central forms control authority. Upon receipt of the request, he should thoroughly investigate the circumstances. A change in a form usually indicates a change in procedure.

After reviewing the old form and determining what recorded data is necessary, he must study the proposal for the new form. Sometimes the department requesting omission of certain data may not know that it is used elsewhere in the hospital. The forms control authority may find the data in question is available on a form currently used in another department. This second form may more efficiently fill the need.

Consider the example of a form for which revision is requested. The data to be dropped is required by another department. The former department in all likelihood feels strongly that the information should be omitted because it would simplify their operations. It is the responsibility of the forms control authority to determine how to provide the information.

The study now moves from forms control considerations into problems of procedures analysis and work simplification. Since comparatively few hospitals have a procedures unit, work simplification will, in large part, be a responsibility of the forms control authority. He will analyze the procedures of which the form is a part and will study the requirements for and use of the data in question. To accomplish these studies, he should use a flow chart —a graphic representation of the clerical work involved in a given procedure. With this chart he will be better able to devise new and improved ways of doing the job and providing the required data.

A continuous review of current forms is one of the basic elements of a forms control system. In hospitals as in most organizations, there is a tendency for forms just to come into being. Twenty years ago someone in authority decided there should be a form for a certain purpose, so for the past 20 years the hospital has been using it, never quite knowing why.

Every form should be reviewed at each reprinting. Without continuous review, forms will run your hospital. Forms are designed to facilitate work and become a part of procedures. Once in use, forms become a part of staff's routine, deeply imbedded in the daily work habit. They tend to channel thinking and make procedures automatic. A continuous review of forms will make them good administrative aids and help to accomplish the hospital's business.

FORMS CONTROL CHART

Data	Admittance & Discharge Report #694	Patient's Account #126	Patient's History #222	Pathological Specimen Report #241	Laboratory Report #242
Name	X	X	X	X	X
Age	X	X	X	X	X
History No.	X	X	X	X	X
Address	X	X	X		
Emergency Addressee	X	X	X		
Service	X	X	X	X	X
Class	X	X	X		
Date Admitted	X	X	X		
Time Admitted	X	X	X		
Date Discharged	X	X	X		
Physician	X		X		
Room	X	X	X		
Treatment History			X		
Family History			X		
Tests to be Made				X	X

Presenting the facts of hospital life

. . . through children's essay contests

ANNETTE N. HONAN

SEVERAL COMMUNITIES are using children's essay contests as a public relations tool to present the local hospital and bring the facts of hospital life to the public.

To prepare a competitive essay, children have to obtain facts and background. If the parents help, they too will have to do some research. The hospital public relations office can assist by providing material to schools, libraries and newspapers; by arranging for lectures, showing of films, and by scheduling tours of the hospital. The contest must be graded so that children will compete on their own level. All schools in the area should be included. Winning essays can be the basis for news releases that carry the hospital message to many areas not otherwise reached.

At a recent Hospital Prize Award Tea to which children and their parents were invited, an 11-year-old's winning paper closed with this paragraph:

"When I made myself push through the big revolving door of the hospital with my classmate I was frightened. A lady at the desk smiled at me. I felt better. It was that way right along. The more I saw of the hospital, the more I thought, 'If I *had* to be ill, this would be a good place.' My little brother is to have his tonsils out and I am glad I know what a hospital is like."

Acceptance or understanding of this kind from as many people as possible in the hospital area is the true aim of the contest idea.

The chairman of an essay contest conducted with exceptional thoroughness throughout several schools in a Westchester community says, "From the beginning I stressed to our woman's board . . . you must not expect to measure results . . . in *dollars*." She showed wisdom in preparing those who backed the program not to expect the impossible. Her board later recorded that the popularity of the contest had undoubtedly put the hospital into the thinking of many people who had previously been uninterested in it or unaware of its existence. The success of a subsequent fund appeal for capital expansion was attributed at least in part to the effectiveness of the contest in making people aware of the hospital as a factor in their individual and family security.

School interest and cooperation for any contest program are most important. The head of a high school English department who also is chairman of contests stated that he received more than 200 requests annually for his students to enter contests set up to promote as many worthy causes. He and his students were wary of essay writing. But the following ideas "sold" him on a hospital essay contest:

1. The voluntary general hospital belongs to the community it serves and, as a permanent institution, has a place in the democratic society in which we live.

2. Many adults are afraid of hospitals. School years are the time to overcome this fear by having the hospital's true role made very clear, i. e., people go to the modern hospital to get well; everything possible is done to help them get well as rapidly and comfortably as possible.

3. To make the contest interesting to participants, there will be: (a) Prizes—possibly $10 as a first prize and $5 as a second prize for *each grade level.* A nursing scholarship might be the reward for an outstanding piece of writing from high school girls. (b) Recognition —a contest conducted for the White Plains Hospital in 1950 offered no monetary reward but through the cooperation of the editor of a local newspaper, three leading essays were published, together with a picture of their authors.

CONTEST RULES

If a good job has been done with each school head and teacher concerned, the students will be receptive to the proposed program. The rules of the contest should be made quite clear. They may be presented, for example, as a simple typewritten sheet of directions for posting on school bulletin boards. One sheet should be sent to each person who is to judge the entries, and another copy given to the newspapers.

The rules may be embodied also in an official entry blank. These should include a paragraph of hints to contestants as to what is wanted, and a suggested subject on which to write. The number and kind of contests should be listed; so many each week for a period of time, by grade level or school. Prizes should be listed and accompanied by a description of any events, such as arrangements for hospital tours and a final Award Tea.

It may be necessary to speak to classes or to talk before a general

Mrs. Honan is public relations officer at the White Plains (N.Y.) Hospital.

school assembly about the hospital and the contest plan. A film about hospital activities may be shown here to advantage. Recent publications issued by the hospital, relevant historical data, press clippings and photographs can be made available to the school for library reference.

A hand-out leaflet, made up in simple question and answer form or attractively printed with plenty of white space, line drawings, or photographs can be distributed for general information. A guide to the hospital—if only a sheet of directions for staff or volunteers who will conduct groups on tour—is essential. If the budget permits, such a guide can be expanded into a publication that will be useful for some time.

Some hospitals find it helpful to place the contest in the hands of a special committee. But unless the committee is understanding and well briefed, their support will be ineffective.

It may be a good idea to have volunteers address school assemblies. Only those experienced in presenting the hospital story should be permitted to speak. Volunteers, such as a Junior League group, can give most valuable assistance when indoctrinated as to what to say and what to show in taking children on tours.

VISITING THE HOSPITAL

It is desirable to schedule as many children as possible from as many schools as possible for conducted tours. This is a problem, however, since most hospitals do not admit visitors under 14 years of age above the first floor. Hospital public relations officers therefore are tempted to compromise by having two or three boys and girls from each grade level, rather than entire classrooms, visit the hospital. It may be suggested that "representatives" convey observations back to their school as a whole, by means of articles in their school publication, by drawings or in oral reports. But entries to any essay contest based on hearsay information are neither inspired nor inspiring. A better plan is to arrange for a series of contests, perhaps a contest in *one* school year, so that all children are given like opportunity to observe the hospital directly.

Fortunately the hospital's role in the community can be effectively demonstrated by taking groups to sections other than patients' floors. This eliminates the operating room floor, and the pediatrics and nursery sections which may be shown by photographs or a film. Even the under-14-year-old group may be conducted through the remaining four-fifths of the hospital to examine auxiliary services such as x-ray laboratories and diet kitchens. These prove stimulating to youngsters when they are told how such services fit into over-all patient care.

TOUR ITINERARY

An itinerary of this kind was provided for pupils of local schools during an essay contest conducted on behalf of the White Plains Hospital. In this instance visiting groups were staff conducted. It was thought advisable to take not more than six to 10 at one time. The itinerary plus experience notes was somewhat as follows:

1. Meet group at central entrance and conduct to a place where wraps can be left. This is an appropriate time to tell the group what to look for (such as call lights for doctors and nurses that flash on and off in frames at every intersection), perhaps advice to glance in rooms passed quietly by, as the x-ray laboratory, the pharmacy, or the emergency operating room.

2. Visit boiler rooms and repair shops.

3. Visit the dining rooms and kitchen, if these areas are not too busy, pointing out some of the out-of-the-ordinary equipment.

4. Visit the laundry—to see huge machinery in action.

5. Visit the linen room to view the piles of fresh, white linen.

6. Visit the housekeeping department, where the housekeeper may be willing to give a short talk.

7. Visit physiotherapy, where the whirlpool bath, some idea of diathermy and various therapeutic lights are of interest.

8. Visit the laboratories. Some laboratories must be passed by but others may be looked into more closely. The blood bank challenges interest. In one room technicians may be counting cells under a microscope; in another room a technician may find time to demonstrate blood typing. The histology department holds fascination for inquiring youngsters. This is the place where slides of pathological specimens received from the operating rooms are fixed for permanent recording by the pathology department. A student composition written after a visit to this laboratory begins: "Have *you* lain awake nights wondering what becomes of your appendix after they have taken it from you?"

9. A demonstration that invariably interests children is to have a qualified operator, probably an intern, show the fluoroscope in action.

10. Finish with a quick tour of the hospital grounds and, particularly, a look at the operating room from the outside, where, it may be dramatically pointed out, "lights may be seen while the city sleeps."

Essays entered in the White Plains Hospital contest were judged by a committee of three, representing the hospital, the schools and the press. Winning essays were published, together with a picture of their authors, in the local paper. Another contest conducted by a Westchester hospital on a much larger scale, among many more schools, featured winning essays at an "award tea" to which all participants and parents were invited.

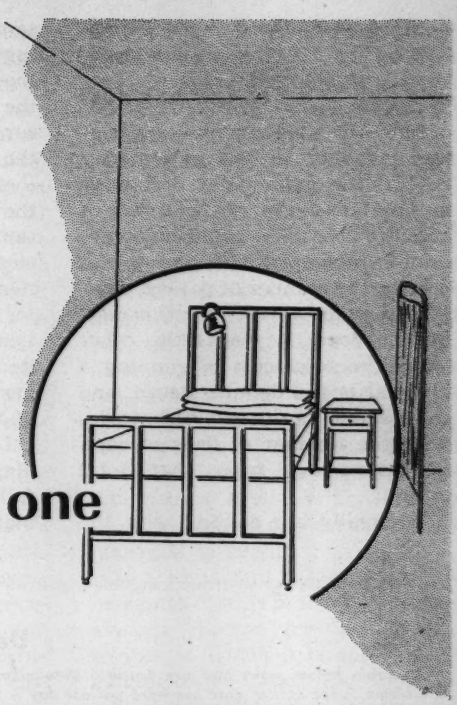
CONTEST SUGGESTIONS

Further light on contest ideas is available from commercial and welfare agencies who have employed them. A magazine called *Contest,* published by A. D. Freeze and Sons, Upland, Ind., is devoted to the subject. *Colliers* published an article on the subject in its issue of December 30, 1950. For years the Westchester (N.Y.) Cancer Society has conducted essay contests among high school students. A "Careers in Nursing" contest sponsored a few years ago by the Southwestern District Council of the Ohio Hospital Association offers helpful suggestions.

Far from new and a lot of work, the essay contest offers itself as a tried and effective tool to administrators who wish to raise the level of community understanding and appreciation of hospital services.

MARGINAL COST PRINCIPLE SHOWS

The most expensive bed in the hospital is the empty one



MARTIN R. STEINBERG, M.D.

IN THESE DAYS of rapidly rising salaries and expenses and not so rapidly rising income, we are looking more than ever for ways of decreasing deficits. One of the most effective methods used by mercantile establishments to increase income depends on the *marginal cost* figure. The hospital administrator can use the same method. To borrow it, he must first understand what it is and how the merchant uses it.

"BARGAIN" SALES

The daily papers carry a constant stream of department store advertisements of bargain sales. Merchandise is offered during these sales at a small or sometimes a considerable discount. The impression the average customer gets is that the goods are being offered at a sacrifice. He thinks the store has been unable to dispose of them because the articles were bought in a larger quantity than was demanded by the consumer. Anyone who knows merchandising realizes, of course, that this generally is not the case. The basis for bargain sales is the use of the marginal cost principle.

What, then, is marginal cost? A department store determines that the cost of selling a piece of merchandise is $2.50. That amount is a compound figure made up of all the direct expenses of selling a particular piece of merchandise plus a predetermined part of all the indirect expenses of operating the store. It includes, therefore, such direct expenses as the manufacturer's or the jobber's charge, freight, tags and labels, boxes and wrapping paper; and many hundreds of indirect items, from part of the cost of lighting the sales area to part of the amortization of the store property, the salary of the president, and insurance premiums.

In figuring the cost of selling the article, the total cost of selling a "normal quantity" of the article is arrived at, and the cost of selling one unit of the article is merely the total cost divided by the number of units. A normal quantity is the quantity the buyer or merchandising manager predicts as the number of units which probably will be bought at regular prices. Regular prices are determined by adding together the price paid the manufacturer, the expenses of selling, and a predetermined percentage of profit, which in merchandising lingo is "the mark-up."

INDIRECT COSTS

The merchandising manager often buys more than he thinks he can dispose of at regular prices with the intention of offering the excess at bargain sales, using a price which takes into account the marginal cost of selling the article instead of the normal cost. The bargain price is determined by computing again the price paid the manufacturer, the same mark-up, the direct selling cost, and only a small percentage of the indirect costs. For the purpose of determining marginal cost, the merchandising manager does not include most of the indirect charges, because he already has written off most, if not all, of such expenses as heat and light for the department, insurance premiums, and other overhead costs in computing the normal or regular price. For example, if the first 200 dresses return to the department all or most of the indirect costs, it is possible to dispose of another 100 dresses using the same space, personnel and facilities, all of which were paid for in the selling of the first 200 dresses.

How can the hospital administrator make use of this method? The administrator has available and uses daily the cost per patient day. This is arrived at by determining the cost of running the hospital or a section of the hospital and dividing it by the number of patient days. The greater the number of patient days, roughly speak-

Dr. Steinberg is director of the Mount Sinai Hospital in New York City.

ing, the lower the cost per patient day.

PATIENT-DAY COST

This last statement gives a special meaning to the patient-day cost. If the patient-day cost were an absolute figure, the total cost of running a hospital could be determined by simply multiplying that cost by the number of patient days. We know, however, that this cannot be done. It works the other way. The total cost of running a hospital is the definite figure, and the patient-day cost, which varies with the number of days of care, is determined from that total figure.

We really are dealing with the same process that the merchandising manager deals with in the sense that the cost of a patient day for the last fraction of patient days supplied is less than the cost for the initial fraction. It is wise, therefore, to compute the cost of the patient day for the first fraction, which is comparable to the cost figure in the regular priced items, and then to compute the cost for the remaining fraction of patient days, comparable to the cost item in the "bargain sale" of a department store which makes use of the marginal cost principle.

Let us use a ward for an example. When the ward is two-thirds full it costs a certain amount of money to run. The cost is computed by totaling the direct cost for each patient (such as drugs, food and linens) and all the indirect costs (such as heating and lighting the ward, housekeeping, x-ray and part of the cost of administering the hospital). If it were possible to fill the last third of the ward, the cost for each patient certainly would be lower than the cost for patients in the first two-thirds, because the indirect costs would not increase, or at least not proportionately. We would not use more light or more heat; our insurance premiums would not increase; the administration costs would be affected only slightly.

THE MOST EXPENSIVE BED

It becomes clear, therefore, that the most expensive bed in the ward is an empty one, and that one of the ways to help balance the hospital budget is to fill all the hospital beds, even the ward beds, and to use all facilities to capacity. The smaller the number of empty beds and the more we use our facilities, the greater the number of units we can sell at marginal cost.

The department store merchandising manager is eager to sell marginal cost units, even at a reduced price. Hospitals should be even more eager to sell marginal cost units, that is, to keep their beds filled, because not only do they enjoy the same decrease in costs but they also sell these units at regular and not bargain prices.

At a recent regional meeting, I pressed the point that we should do everything within our power to keep ward beds filled and to increase the use of outpatient departments as long as there were patients eligible to use them. One member of the audience commented that my argument reminded him of the story of a man who lost money on each transaction but made up the loss because of the volume of transactions. It does seem strange to argue that increasing the number of ward days will decrease the deficit when we know that each ward day produces a loss of $8 or $12. The fact is, however, that the increased number of the last fraction of ward days can be given at a cost lower than the published ward-day cost, and in most institutions it can be

Determining marginal cost

The table below shows how one hospital determines the marginal cost for a ward patient. In Column A the normal cost per ward patient day is broken down into all the parts that make up the total cost. These parts incude both direct and indirect costs. In Column B the marginal cost is determined by reducing or eliminating indirect costs.

	Column A (130,736 ward patient days)		Column B	
	Amount	Cost per patient day	% of A used to determine marginal cost	Marginal cost
General				
Administration	$ 25,666.92	$ .1963	0	
Dietary and food	182,803.50	1.3983	90	$1.26
Housekeeping	68,013.24	.5203	25	.13
Laundry and linen room	41,753.82	.3194	90	.288
Operation of Plant	34,220.61	.2617	0	
Maintenance of buildings and grounds	54,388.55	.4160	0	
Overhead total	$406,846.64	$3.1120		$1.678
Medical and surgical care, nursing, etc.				
Medical and surgical expense	$ 74,681.21	$ .5712	75	$ .4275
Interns and residents	97,098.50	.7427	0	
Nursing care—administrators and graduates	433,106.75	3.3128	5	.1656
Nursing care—orderlies and attendants	106,757.24	.8166	5	.040
Student nurses—allowance and maintenance	134,616.69	1.0297	0	
School of nursing	123,163.18	.9421	0	
Pharmacy	52,337.43	.4003	90	.36
Social service	100,046.77	.7653	5	.038
Medical records	47,090.74	.3602	25	.09
Dental department (inpatients)	6,529.02	.0499	25	.0125
Total	$1,175,427.53	$8.9908		$1.1336
Total board and and routine care	$1,582,274.17	$12.1028		$2.8116
Special services				
Operating rooms	$189,783.24	$1.4517	30	$ .435
X-ray	55,757.87	.4265	25	.1065
Laboratories	214,001.93	1.6369	25	.41
Physical therapy	11,140.34	.0852	10	.0085
Metabolism	3,050.72	.0233	10	.002
Electrocardiograph	10,853.90	.0830	10	.008
X-ray therapy	7,301.99	.0559	10	.006
Blood bank	45,345.49	.3468	50	.1734
Total	$537,235.48	$4.1093		$1.1494
Over-all total	$2,119,509.65	$16.2121		$3.9610

given at a cost lower than the average income from this fraction. The income, unlike the cost, is not affected by whether the patient is in the first or the last third of those admitted to the ward. If, then, the marginal cost is less than the average income, there is a financial gain for each patient day and, of course, a decreased deficit. In effect, the statement that we can lose money on each transaction and make it up because of the volume of transactions may sound paradoxical, but it actually can be true.

FINDING MARGINAL COSTS

The determination of marginal cost, like all cost determinations, depends on certain arbitary accounting decisions. One can, for instance, arbitrarily assume that the first two-thirds of a ward or an area of beds should bear all indirect costs or that the first half should bear them. A simpler and perhaps more accurate method is to determine the ward patient-day cost in the usual manner, by dividing the total cost of running the wards by the number of ward patient days, and then to break down the ward patient-day cost into all the elements that make up the total ward costs. The next step is to take each of the elements and separate the direct from the indirect. The marginal cost then is determined by adding to the direct costs a varying percentage of the indirect costs.

The method used at our hospital varies slightly from that described here. We compute first the consumption cost per patient, that is, the cost of things actually consumed or used up by the patient. This includes the cost of the food the patient eats, the drugs he receives and the laundering and replacing of linens he uses. We add to the consumption cost a varying percentage of some of the indirect costs, ignoring other indirect costs which we feel are not affected by adding the marginal cost patient to the normal load. The percentage of indirect costs added is an arbitrary one since it would be most difficult, if not impossible, to determine accurately the actual percentage.

Let us take, for instance, the item of operating room expense. The fact that we have an added patient might mean that there is an added operation to be performed; it does not mean that we will add an operating room nurse, but it will mean that the cost of running the operating room will be greater because more anesthetics, sutures and other surgery essentials are used. We, therefore, do not apply the same formula in computing the percentage of operating cost attributable to this patient. We add a little more than one-fourth of the normal percentage, based on the fact that we can ignore the salaries of operating room personnel.

In Column A of the table is shown our hospital's cost per ward-patient day for 1949. The cost is broken down into all of the components used to arrive at the total. In Column B we apply the principle of determining marginal cost by reducing or eliminating items of indirect cost.

Generally speaking, if the cost is for items consumed by the patient we use the factor of 90 per cent; if the patient consumes very little material, such as in physical therapy, the factor used is 10 per cent; if the amount of material and service given by the department to each patient is a determinant, as with medical records, the factor is 25 per cent, and, finally, if the addition of the marginal patient produces no increase in expense, the item is ignored and the factor is zero.

DECREASED DEFICIT

As shown in the table, the cost per ward-patient day for the year is $16.21, while the marginal cost per ward-patient day is $3.96. Our income per average ward-patient day during 1949 was $8.70. Depending, therefore, on how accurate was our determination of marginal cost, our total deficit would have been less by $4.74 for each extra ward day we could have managed to supply.

It is important to determine the marginal cost. If it is less than the average income for the unit of service to which it is applied, the administrator and the hospital should advertise this information within the hospital and stimulate the fullest use of facilities. Full use is socially valuable, for community service is the reason for the existence of hospitals. The use of marginal cost is a good sales and psychological method of stimulating all concerned to insure achievement of the socially useful goal.

The intern matching plan

THE OVERWHELMING support for the intern matching plan proposed by the National Interassociation Committee on Internships, reported in the September issue of HOSPITALS, has been followed by an even greater response in actual participation. This indicates that even those who were opposed to the plan are willing to give it a try. All but 19 approved hospitals have now agreed to participate in the plan and the door is still open for these to come in. The Directory of Participating Hospitals has been published and circulated to all hospitals concerned.

The directory was published hastily but the need for speed was greater than the need for accuracy. There is no index and a few errors have been noted. The errors will be corrected and additions made in the supplement to the directory, which will be distributed about November 15. Another year should see a more finished job.

In spite of its shortcomings, the directory contains much valuable information that is not available elsewhere. It lists a total of 10,321 internships. Sixty different types of internships are offered. General rotations account for 8,418 of all the internships or more than 80 per cent. It is hoped that the new matching plan will finally solve a problem that has plagued hospital administrators for many years.
—CHARLES U. LETOURNEAU, M.D., *secretary, Council on Professional Practice, American Hospital Association.*

CHAPLAIN Claude M. McClure of Methodist Hospital, Indianapolis, and his secretary examine card files of student prospects. Chaplain McClure directs the Indiana Methodist Student Nurse Recruitment program.

SUGGESTIONS BASED ON SUCCESS

The DO's and DON'T's of a nurse recruitment plan

GEORGE R. WREN

SUCCESSFUL recruitment of student nurses always represents hard work; but this work can be made more difficult by confusion in the central organization, wasted efforts by the recruiters, or misunderstanding the function of each person in the program.

With three years' experience back of it and a highly successful record, the Indiana Methodist Student Nurse Recruitment Plan has discovered many of the problems involved in organizing for nurse recruiting. From our experiences we have been able to set up certain guides in terms of right and wrong procedures.

As background to the recruitment program, in July 1948 the Methodist Hospital of Indianapolis was suffering from the same critical shortage of nurses that was afflicting most of the nation's hospitals at the time. An intensive student nurse recruitment campaign started in July 1948 (still in progress), was the answer to this shortage of graduate and student nurses. The program was financed initially by a public-spirited Indianapolis businessman and later by hospital funds. It utilized, as its framework, the Methodist Church organization in the state.

APPLICANT is interviewed by Mrs. Shirley Fowles, the nursing school assistant director.

Since the inception of the program, the Indianapolis Methodist Hospital school of nursing has had capacity classes. The quality of students who have entered under the recruitment program has been as high or higher than for non-recruitment students. The class averages have been as high and the withdrawal rates as low for the 1948, 1949 and 1950 classes as were the class averages and rates of withdrawal for classes which entered prior to July 1948.

STATE-WIDE RESULTS

By stirring up interest in nursing among the high school girls of the state, the Indiana Methodist Student Nurse Recruitment Plan no doubt has helped increase the nursing school enrollments at the Methodist hospitals in Gary and Fort Wayne, as well as at the Protestant Deaconess Hospital school of nursing at Evansville and all other Indiana nursing schools.

Hospital personnel active for the past three years in running this intensive and successful statewide student nurse recruitment program have gleaned several pointers from their experiences. These guides, which appear on the next page, apply to the central organization that plans the recruitment program, to the actual recruiting by volunteer workers, and to the relationship of nursing school personnel to prospective students.

No program can be successful without the whole-hearted support of the entire hospital organization. The recruitment campaign must be sold to everyone concerned. This includes the board of trustees, the nursing school committee, the director of nursing, the school's faculty and the hospital administration. To have a really successful recruitment program, everyone participating in the program must believe in it.

Mr. Wren is superintendent of Methodist Hospital, Gary, Ind. This article was prepared while he was administrative resident at Methodist Hospital, Indianapolis.

DO

DO have your recruitment program well organized, planned and coordinated in order to avoid wasted effort and funds.

DO have a special recruitment organization with individuals having definitely designated jobs even if these are in addition to their regular hospital duties.

DO have some money to run your recruitment program. The total cost of the Indiana Methodist plan for two and one-half years was estimated to be approximately $7,000. This amounts to a cost of about $62 for each student recruited by the program.

DO have scholarship funds available if you intend to appeal to girls on all economic levels. Approximately one-third of the students in each entering class at the Indianapolis Methodist Hospital school of nursing receive scholarships covering full tuition, books and uniforms. A drive for scholarship funds was an integral part of the early stages of the student recruitment program.

DO use existing organizations as much as possible in your recruitment campaign. The Indiana Methodist plan depended on the organization of the Methodist Church in Indiana for the framework of its campaign. Other church organizations, fraternal groups and veterans' organizations could be used similarly as the framework for all or part of a recruitment program.

DO get as much publicity as possible for your recruitment program. Releasing publicity from a central source was more successful than depending upon local recruitment workers to place newspaper articles. When you have a recruitment meeting or program, do not neglect both pre-meeting and post-meeting publicity.

DO subscribe to a press clipping service if your recruitment campaign is more than city-wide in scope. Compile the results of your publicity from the clippings and work to get publicity in areas where you have had none.

DO keep adequate and complete records on all prospective students. The Indiana Methodist plan maintains three files on prospects, all records on three-by-five-inch cards. One file is of cards filed alphabetically, the second file is composed of cards filed by year of graduation from high school, and the last file is made up of cards filed by locality. On the cards are noted the girl's name, address, name of recruitment worker reporting the prospect, date of anticipated graduation from high school, dates of all correspondence sent to the girl, and results of her application for admission to the school.

DO have a logical follow-up on student prospects reported by recruitment workers. Write to the prospect immediately on receipt of her name even if she is only a high school freshman; then contact her again during her senior year when she is eligible to apply for admission to the school. Continue to write to prospects even after they have graduated from high school. Getting a prospect's name is the first step; proper follow-up secures the girl for your school.

DO interview student prospects freely. All prospects reported to the Indianapolis Methodist Hospital school of nursing receive a letter inviting them and their parents to have a conference with the director of nursing. If prospects can be seen before they are seniors in high school, the director of nursing can advise the girls on their high school curriculum to prepare them to enter nursing. The earlier in their high school program prospects are contacted by the director of nursing, the better qualified applicants there will be graduating from high school.

DO use extreme care when candidates are not accepted by the school. This is important for the hospital's public relations, for the girl who is not accepted, and for the recruitment worker who submitted the applicant's name and upon whose future work the continued success of the recruitment program depends.

When candidates are not accepted, the Indianapolis Methodist Hospital school of nursing sends out three lengthy letters. One goes to the applicant telling her exactly why she was not selected, calling attention to the high requirements of the nursing profession, and perhaps suggesting some course of action for her, such as applying to a smaller school, going on to college, or entering practical nurse training. The letter to the recruitment worker who submitted the girl's name as a prospective student tells him exactly why the girl was not selected, calls attention to the high requirements of the nursing profession, and thanks him for his efforts on behalf of the recruitment program. A letter is sent also to the girl's local minister asking him to call on the girl.

DO have the regularly constituted admissions authorities (such as the director of the nursing school and admissions committee) select the entering students by commonly recognized criteria. The recruitment program's function is to secure candidates for admission to the school. Campaign workers or the donors of campaign and scholarship funds should not influence admission policies. The Indiana Methodist recruitment plan was free of such pressure which is one reason why the campaign has been successful without lowering admissions standards.

DON'T

DON'T waste time and money on recruitment workers who do not understand the qualifications of a nurse or the type of applicant you desire. Be sure the recruiters concentrate their efforts on prospects most likely to be accepted by the school.

DON'T "high pressure" girls into entering your school. If the girl is not accepted this may easily result in disappointed applicants and bad hospital public relations. It also may result in an abnormally high withdrawal rate when the "high pressure" and glamour wear off. Nursing has so many advantages that it will sell itself to girls if fairly and properly presented; this is the keynote of the Indiana Methodist plan.

DON'T appeal to girls on a purely emotional basis. Don't get them to enter nursing just because the hospital needs them badly. Make sure prospects realize that every girl cannot qualify as a nurse. Avoid telegrams, special delivery letters and personal telephone calls that may give her the idea that her entrance is of vital importance to the school. If a girl is influenced to apply for admission to a nursing school by an emotional appeal stressing society's or the hospital's tremendous need, how can she, her parents and her friends understand if the school does not select her as a student?

The mysterious "Dr. X"

ON SEPTEMBER 22, a newspaper in Portland, Maine, carried this headline: "AHA Making Secret Survey of Hospital, Surgery Practices." In Wilmington, Del., the headline read, "Secret Doctor Investigating Patient Care by Hospitals." A daily in Asheville, N.C., printed this headline: "Hospital Care of Patients is Questioned. Nationwide Survey Will Be Conducted." In Louisville, Ky., it was, "Doctor X Checks Up—Undercover Survey Is Being Made of Quality of Hospitals' Patient Care. Avoidable Deaths One Criterion." Other papers in other areas had similar headlines.

All of these headings referred to the same wire service story, datelined St. Louis, September 21, which read, in part:

> How many surgical operations are unwarranted? How many deaths are avoidable? Do patients who are seriously ill get the correct treatment?
>
> The answers to these and other questions are being sought in a country-wide inquiry known only as "Project X." Its existence was disclosed Thursday night at the concluding session of the American Hospital Association convention here.
>
> An intern, whose name is a secret, is the field man in the investigation. He is going around the country looking into the quality of patient care provided by individual hospitals.
>
> The project is sponsored by the W. K. Kellogg Foundation in the hope of developing standards for evaluating medical care. It was explained by Andrew Pattulo of Battle Creek, Mich., the foundation's director of hospitals.

In the first place, of course, the Portland headline writer was off base in saying that the American Hospital Association is making such a secret survey. The Association is doing nothing of the kind. It has done nothing of the kind. It plans to do nothing of the kind.

In the second place, there is no such country-wide inquiry being made by *anybody*, the W. K. Kellogg Foundation included.

In short, Mr. Pattulo was misquoted.

The Kellogg Foundation *is* sponsoring a localized and highly limited project in Michigan. To date this has consisted of a study of one rural hospital, and it came about at that hospital's request. The person who made the study is not an intern but an *internist*, a diplomate of the American Board of Internal Medicine. This internist is not "going around the country looking into the quality of patient care provided by individual hospitals." After he finished his study of the one hospital, two other institutions in Michigan asked the Kellogg Foundation for similar help, and these requests were approved.

The studies are being made not to "check up" on hospitals, as the Louisville headline indicated, but to help these rural hospitals to develop a sort of expanded medical audit—a simplified and inexpensive method by which their medical staffs can evaluate their own professional work.

In the one study that "Dr. X" completed, indications are that he was successful in developing new criteria by which staff physicians and surgeons can check up on themselves. At a special meeting, the medical staff of that rural hospital was shown the results of this study, and to a man the staff's reaction was favorable. The report that "Dr. X" presented did indicate flaws in the staff's professional work. Using this report as a basis, the medical staff got busy and did some needed housecleaning on a self-governing basis.

This misinterpretation of facts in itself is not of great significance except as it may have put doubts into the public mind and made hospital administrators unduly nervous. But the fact that such an incident occurred, despite Association efforts to help convention reporters get the accurate interpretation into their stories, points up one of the many ways in which the press can unwittingly go wrong in reporting hospital news. It serves as a reminder of the importance to hospitals of working closely with the press.

In the case of the story of "Dr. X" full advantage was not taken of the help that was available, and this was probably because of an impending deadline. But most reporters are reasonable people and normally they will go to great lengths to get their stories straight—provided they are offered the right kind of assistance.

A bright sequel

MUCH HAS BEEN WRITTEN and said about Perth Amboy (N.J.) General Hospital—how its carefully conceived disaster plan swung smoothly into effect twice within nine months when major catastrophes struck and how its medical staff and its employees worked diligently through long and tragic hours.

Now a new chapter has been written. It is not a sensational one. It rated only a few inches on an inside page. Yet its importance cannot be overstated: The medical staff of the Perth Amboy General Hospital has placed in the hospital's building fund a check for $32,509. This check represents the payment that these physicians received from the Pennsylvania Railroad for rendering medical care to the 94 victims of the February 6 train wreck. In the words of Hospital President Charles E. Gregory, this was "a most magnanimous gesture which reflects great credit upon their profession."

As one of its many publicity and fund-raising projects, Long Island's North Shore Hospital sponsored an art show, an idea that could well be used by almost any hospital

A hospital-sponsored community ART FESTIVAL

EDWARD E. JAMES

LATE-WINTER APATHY was beginning to be felt by the North Shore Hospital fund-raising campaign committee last January. A new angle was needed—particularly a new publicity device to attract the interest of a group in the community that had not been directly contacted by the hospital fund's horse show, benefit athletic events and star nights.

This need for a new appeal to a new segment of the population resulted in one of the most unusual promotional events that the hospital fund has attempted—an art festival.

While by no stretch of the imagination anything but a minority group in the six communities North Shore Hospital will serve, the art patrons, the artists themselves and the art public are nonetheless an important and articulate community element. To capture local attention, it was decided that the show would feature work only by Long Island artists.

From the very beginning the primary objective of the show was to gain publicity in a favorable and unusual context for the building fund. Everyone realized that a show restricted to Long Island artists could not make art history, yet the educational value of a regional show was thought to be considerable. As a money-making effort the art show was felt to be questionable, although at the least it was

WITH PART of the Art Festival audience looking on, Gwen Lux, noted sculptor, demonstrated her craftsmanship by modeling in clay Joyce Matthews, radio and television star.

Mr. James is director of the North Shore Hospital, Great Neck, Long Island, N. Y. For other fund-raising ideas used by North Shore Hospital, see Mr. James articles, "Ground-breaking—A Fund Raising Potential," in HOSPITALS for July 1951, and "Promotions Are the Key to Fund-raising Success," in HOSPITALS for August 1951.

OPENING NIGHT was a gala affair, with Trustee President Mrs. Joan Whitney Payson (at left); Mrs. Barbara Field Boggs, Art Festival chairman, and Edward E. James, hospital director, on hand to greet guests. At the back is a picture of the proposed hospital.

expected to break even financially.

Actual planning of the Art Festival, as we named it, started with a search for a suitable exhibition building. No place near the hospital site was available or large enough. At length a building nearing completion for later occupancy by a chain department store was found. Store officials very generously agreed to postpone their opening to allow the exhibit to be held. With a location found, the Art Festival definitely was scheduled.

At this point local art groups were contacted to help organize the exhibit. A jury of recognized art judges, persons holding positions in New York City museums, was formed to set up rules governing entries, to judge suitability of entries and to award prizes. Entry blanks were printed and distributed to all art clubs and schools in the area. An industrial designer was called in for advice on utilization of floor space and to assist in preparing detailed plans for temporary partitions that would show the pictures to best advantage. Among other arrangements was the purchase of an insurance policy protecting owners from loss or damage to paintings while in our possession.

MEMBERS OF THE art committee, all representatives of metropolitan museums, selected 600 entries for exhibition in the North Shore Hospital Art Festival and awarded prizes.

ENTHUSIASTIC RESPONSE

Public acceptance of the art show was excellent. Paintings came in by the hundreds, and 600 were accepted for display. Fund drive employees found themselves developing an extensive vocabulary of art terms and phrases. Publicity photos were taken and news stories run in local papers.

Thirty-six hours before the scheduled opening of the show, plasterers were still working atop scaffolds in the store. Carpenters were nailing down floors, and electricians hanging fixtures. Heat for the building was not available until the day of the opening. A few hours before the grand opening a crew of carpenters erected the temporary partitions just in time to have paintings hung by volunteers. Timing was so tight that some exhibits were not hung until invited guests were actually entering the display area.

Opening night was an invitation affair, with a caterer on hand to provide refreshments. Outside, a huge searchlight played on the front of the building and flashed about the sky in the best first-nighter tradition to attract public attention. The searchlight was used every night of the show, and the public never failed to investigate the source of the moving finger of light.

Sponsorship of the art show was not the only way the hospital building project was brought to the attention of the public. Inside the main door of the exhibit was a display of the proposed hospital building, featuring the architect's per-

spective and a set of blueprints. At all times employees of the fund were on hand to greet visitors, answer questions and give out pledge cards when possible.

ART DEMONSTRATIONS

No admission was charged on any of the five nights of the Art Festival. A sign posted near the entrance, however, suggested a donation of $1 per person, and nearly everyone followed the suggestion.

Special art features kept up interest in the festival. Exhibit floor space had been so designed that a demonstration area was in one corner of the main floor. Demonstrations of various art techniques—sculpturing, preparation of plates for etching, water color, portraiture—were conducted nightly by well-known artists who donated their services. Motion pictures of art subjects were shown in an educational section. On the closing night, when a large public party and art auction took place, there was a "painting bee"—a contest in which teams from local art clubs competed to see who could turn out the best painting of a common subject in a given period. Results were amusing, and both the public and the contestants enjoyed the unique competition.

Clean-up after the festival was relatively easy, with the major problem being the storage of entries until they were called for.

NEIGHBORING schools cooperated in the art show by entering educational exhibits.

The Art Festival lived up to expectations in every way. As a publicity device it provided coverage that straight news stories never could offer. Dollarwise, it was satisfactory; the show made a moderate profit. Some new pledges were signed. More important, new people learned of the need for the hospital and the planning that has gone into the project, and are now on the fund mailing lists. Artistically, the show was an unqualified success. As a result many art enthusiasts have a warm feeling about the North Shore Hospital that may ripen into friendship later.

An unanticipated result of the art show was sponsorship of a number of benefits for the hospital building fund by various art groups. None of the benefits will produce a large amount of money, but the gross will be substantial, and welcome.

Publicity and a variety of benefits held prior to the Art Festival by the North Shore Hospital fund-raising committee paid off handsomely: A million dollars were raised in a year at an overhead expense of only five per cent. From our experience with the Art Festival, we believe it is a new publicity device offering special interest for a particular group in the community. This special interest, however, is not at the expense of general public appeal.

The Art Festival was a Long Island "first." It was undertaken only after careful study, and then with considerable questioning of the wisdom of sponsorship of an art show by a hospital building fund. Throughout, it proved to be a thoroughly respectable and refreshing project with which to be associated. It could prove to be a good public relations device for any hospital in an area populous enough to support such a specialized project.

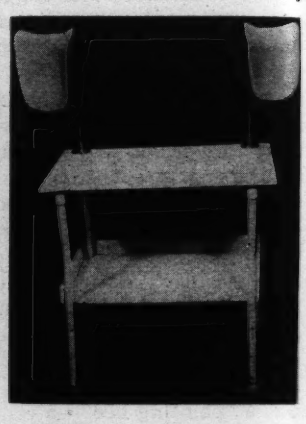
AUCTIONEER Jinx Falkenburg McCrary receives bids from the crowd on closing night.

Three useful inventions

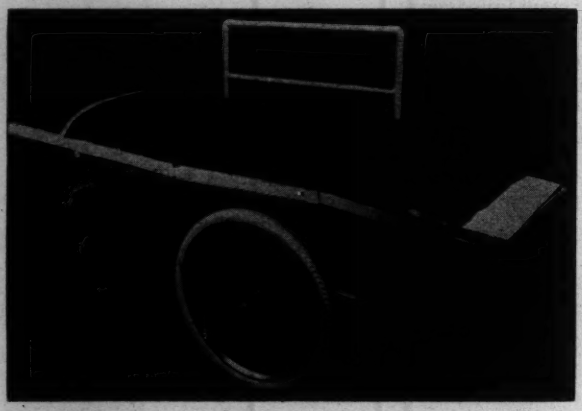
1. Pelvic examination table
2. Litter-wheelchair
3. Bedside commode

WILLIAM J. BURKE

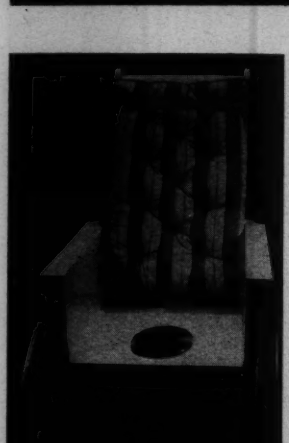
WORKING in the wards of a large hospital, employees and physicians learn that many frequently performed routines are time consuming and cumbersome. New equipment is needed for better care and streamlined operations. The author, an orderly at Peter Bent Brigham Hospital, Boston, designed these pieces of equipment, each of which answers a definite need on the wards and contributes to better patient care.



1. WITH THE TABLE shown at right, pelvic examination and instrumentation can be performed at the bedside. The patient is turned across the bed, the table wheeled to the bedside, and the knees placed across the cradles. Instruments and medications are placed either on the lower fixed shelf or the upper hinged shelf.



2. SAFE, early post-operative activity is possible with the bed-chair. When side boards are removed and back and leg portions extended, the patient is moved from his bed to the bed-chair. It can also serve as a standard litter or emergency operating table.



3. BY removing the seat cushion from the chair and placing a bed pan beneath the seat, a satisfactory commode is achieved. The bed pan is concealed in a practically air tight compartment when not in use. This chair is used when either toilet or pan in bed is not convenient.

A physician's work for a hospital might be compared with the work an attorney does for a trust company. When the lawyer offers legal advice as part of his trust company duties, is the company practicing law?

Hospitals and the practice of medicine

A trustee's viewpoint

ROBERT CUTLER

IN A DISCUSSION of hospitals and the practice of medicine, a subject with many areas of disagreement, it might be well to begin with some basic propositions on which perhaps there is some agreement.

First, I am desperately concerned over the continued future existence of the great teaching hospitals which give free care—as we have known and know them. I am president of such a hospital. In our wards, from one-third to one-half of the second-year, third-year and fourth-year students at the Harvard Medical School receive their clinical training.

To meet the ever-increasing gap between operating receipts and operating expenses, we depend more and more, as endowment income is consumed, on voluntary contributions from the public at large. The mounting uprush of costs and wages has caught us all in the "big squeeze." I am fearful that we shall be squeezed to death; that some new form of operation and control will inevitably grow out of this death; and that as the capability of a free people to support these great works of charity wanes—under the crushing weight of governmental waste and confusion—so the life-stream of their freedom will ebb away also.

I believe in works of voluntary charity. I believe they are coterminous with spiritual liberty. But we are in deadly peril. In the first six months of this year my hospital's net deficit, after all receipts, was three times the net deficit for the whole of 1950. With other great teaching charity hospitals the story is the same. The continuance of such losses will drain away endowments to meet current deficits. Without the income from endowments to help, I fear that the nation's community funds will be unable to raise enough from the tax-ridden public to bridge the gap.

Here then is a moment in time that calls for sound business principles in hospital administration; that calls for looking at the hospital as an integration of all essential services for patient care; that looks to the financial viability of the hospital as a total unit, rather than to the profits or losses of different departments or divisions thereof—if indeed they can be separately measured.

If ever there was a time for the hospital and the doctors to join hands and present a united front, the time is now. If by such united strength we cannot preserve the great tradition as we have known it to flower in American medicine, then it will little matter how any of us plan or fret or contend for rights and privileges, because in that new dispensation all these matters will be *ordered* for us by a superior power.

A second basic proposition for agreement is this: Can we not also agree on the capacity of men and women of good will to come to a fair and reasonable settlement of any matter?

I have formed the opinion that 99 per cent of the American people are as good as they come; as for the balancing fraction, they are not important and we should forget them. I firmly believe that Americans, when they have the mind and the will to do so, can compose amicably all differences—no matter how serious—with justice for all.

To decree certain things from central authority which should be left for decision to the folks back home is unsuited to the morale of a free people. More good sense and fresh air prevails at the local level than in the stratosphere. Let the people back home determine some of the large moral, ethical and civic problems that arise in each community.

Third: Can we attempt also to describe the modern hospital of the kind to which I have referred? Recently I saw it described as "a complex organization utilizing combinations of intricate, specialized scientific equipment, and functioning through a corps of trained technicians educated to the problems of modern medical science. These are welded together in the common purpose of restoration and maintenance of good health . . . The patient is the focal point about which

Can it be said that hospitals are practicing medicine if the departments headed by salaried specialists show operating incomes in excess of expenditures? Physicians and hospital administrators have often stated their views on this subject. Here is what a prominent hospital trustee thinks about it.

Mr. Cutler is president and trustee, Peter Bent Brigham Hospital, Boston. This is adapted from a paper presented at the American Hospital Association convention in St. Louis, September 1951.

all activities of the hospital revolve."

This definition impresses me with its emphasis upon the hospital as a unit fused together of many component elements.

The modern hospital is no longer a workshop for individual doctors. It is a field for team play. And the team play is directed not toward the trustees or the administrator or the doctors or the aggregate entity called the "hospital," but toward the patient.

Now it is against the backdrop of these principles, if I may call them such, that I wish to comment upon two aspects of the controversy which has been stirring over what is called the "exploitation" by hospitals of the specialists in radiology, pathology and anesthesiology.

Where there are abuses or exploitation or short-sightedness, they are not to be condoned but are to be corrected. But they can be better corrected if we call a spade a spade and attribute a malady to the true motivating cause.

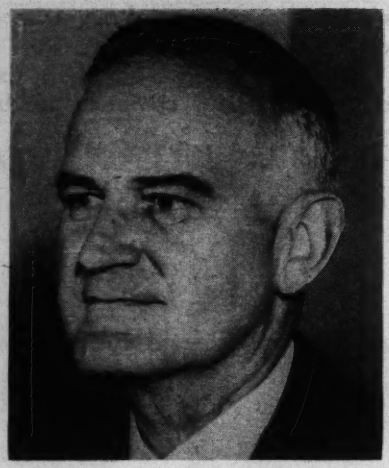
Two positions, in particular, have been advanced frequently as somehow being the key to this troubled relation between the voluntary hospital and the specialist on its staff. One of these positions is expressed in legal terms. The other is placed upon ethical grounds. It seems to me that neither of these lines of argument is sound, and that they confuse rather than clarify.

LEGAL VALIDITY

In the first place, it is said that for a hospital to collect and retain all or part of the fees earned by a doctor on its visiting staff for services performed within the hospital, meanwhile paying to the doctor a salary which is less than the net profit of his work, is to constitute the practice of medicine by the hospital. And, the argument runs, no hospital can be licensed to practice medicine; only individuals may be so licensed.

A hospital is a corporation. It is a corporation chartered by the sovereign state to care for the sick, in its wards and in its outpatient department and even in their homes.

How is a corporation to care for the sick? In 1612, in the Case of



MR. CUTLER

Sutton's Hospital (10 Co. Rep. 1, at 32b), the court pointed out that "a corporation aggregate of many is invisible, immortal, and rests only in intendment and consideration of law . . . (The corporation) cannot commit treason, nor be outlawed, nor excommunicated, for (it) has no soul, neither can (it) appear in person, but by attorney." This quaint and ancient language expressed in modern dress would read like this:

"Corporate powers and purposes can only be expressed and performed through natural persons acting as its officers and agents. They are the means, hands, and heads by which corporations normally act." (Hunt vs. Stromberg Motor Devices Co., 215 Mich. 483 [1912].)

A hospital cannot care for the sick, as the state charters it specifically to do, with bricks and mortar, with machines and equipment, with drugs and gauze, with syringes and thermometers. There must be human hands and hearts and intelligences. There must be aides and nurses and general doctors and special doctors. The corporate hospital acts by and through these human beings to perform its charter powers. The acts which they thus perform do not constitute the practice of medicine by the hospital in the sense in which that term is used with reference to the licensing of an individual any more than an act which I do, in bringing to bear my professional legal knowledge on some matter in behalf of the trust company with which I am associated, constitutes the practice of law by the trust company.

Let us explore this simile. A trust company, like a hospital, is a corporation. Each fulfills and exercises its corporate powers through agents. The hospital acts, in part, through professional doctors. The trust company acts, in part, through professional lawyers. Old Colony Trust Company has on its staff four members of the Massachusetts bar, whose entire duties are to advise the trust company with reference to legal questions affecting it in the carrying out of its charter powers. This employment is entirely legal and practically necessary.

The advice which they give to the trust company is legal advice, for which they are paid a salary; but the giving of such legal advice by agents of the trust company does not mean that the trust company is practicing law. In fact, it is a criminal offense in Massachusetts for a trust company to practice law.

This prohibition nicely points the difference. The corporation trust company may rightly employ a lawyer as its agent to advise it with reference to its business and thus carry out its charter powers. What it may *not* do is to employ a lawyer as its agent to advise *others* on legal questions, for that is *ultra vires,* beyond its powers.

DOCTORS AS AGENTS

So I say that, in my opinion, quite clearly it is proper for a hospital to employ doctors to act as its agents in carrying out its charter powers; and such employment does not constitute the practice of medicine by the hospital. Such employment merely constitutes the fulfillment by the corporation of its charter purpose in the only way in which that purpose can be fulfilled.

The method of compensating the agent does not affect this basic concept at all. Whether the doctor is compensated on a salary basis or on some other basis that is agreeable has nothing to do with the exercise of corporate powers, nor can it make such exercise proper or improper. The quantum and quality of compensation is a matter

between the principal and the agent and should be settled by them on whatever basis will appear reasonable and equitable.

PROFESSIONAL ETHICS

The second of the positions to which I have adverted asserts an ethical basis. It contends that it is unethical for a professional man to accept from a hospital a salary for his services, the value of which may well exceed the salary payment.

Unless there is some peculiar sanctity in the profession of a doctor that differentiates him from the lawyer or the minister, and I do not believe there is, this line of argument strikes me as no more cogent.

After my graduation from the Harvard Law School and my admittance to the Massachusetts bar, I was employed by a leading law firm in our state. It was a large office, with ten partners and about 20 "juniors," as we young lawyers were called. We juniors received a salary. Whether this salary was more or less than we were worth depended on the quality and quantity of the work done by a particular junior. When I later became a partner of the firm, I was of the opinion that after the first year or two of natural floundering the juniors returned to the firm more value than they were paid. But no one thought this unprofessional or unethical.

It will be said that the junior law clerk is like the intern, the house officer, the resident; and that during a training period there is no unethicality in a salary arrangement because in that interval the "quids" balance out the "quos." The crux comes, it will be said, when the law clerk is admitted to the law partnership, when the resident in the hospital becomes a pathologist or radiologist or chief or assistant in some other hospital specialty.

Well, I find a difference in relation but not in kind. After I was admitted to partnership in my law firm, I received annually an amount agreed upon, with my consent, by my senior partners. Some years it was more than what I earned, net, after my share of expenses. In other years, it was less. It never occurred to me to figure that I should be compensated in terms of what I contributed to the pot, net; or to feel aggrieved and unethically dealt with if my net share might be less than I earned.

For one thing, I felt a deep pride, which could never be compensated by money, in being a partner of so many fine and intelligent men. I felt a debt to my partners which could be discharged only by the constant exercise of the best talents I had.

In the second place, we partners were concerned for our firm, for its standing, for the rounded service it could offer to clients. We were competent in many fields—taxation, corporate reorganization, labor law, probate and trust work, for example. Not all these fields were as profitable as others, but we wished to provide our clients with a "whole service," capable of solving all their problems.

So we were ready and eager to build our firm in strength; we thought more of the reasonable satisfaction of all partners than of whether each received back his exact net contribution.

I stress this simile because as a professional man I see nothing unprofessional or unethical in taking, by agreement, a salary or share that is less or more than one has earned, net, in a given period. In fact, I think the *high* plateau of professional living is the one where the enthusiasm for the enterprise and one's associates in it transcends and minimizes the financial aspects. It is a pretty poor kind of professional ethics that thrives only in terms of dollars and cents received.

In ethical, professional and moral matters it is often difficult, if not imprisoning, to lay down from central authority general rules to be followed by all people everywhere—or else. We cannot legislate morality. Standards of conduct can be preserved by voluntary agreement where a law would be flouted. So here, I say, a general rule or law relative to the employment by hospitals of specialists would fly in the face of experience.

Each community has its own problems of climate and economics and competition and race and creed. Conditions that prevail in a New Hampshire town of 10,000 with a small community hospital of 20 beds have no reasonable basis of comparison with conditions prevailing in a great medical and teaching center like Boston with more than six general beds per thousand of metropolitan population. The problem will differ in each community and should be settled at that best-informed level, according to the best interests not only of the profession and the hospitals in that community, but especially of the public in that community. I trust to the men and women of good will in each community to work out reasonable and equitable solutions.

Of course there are people less than good in every community. There will be exploiters. But these can be best met and overcome by freedom and action and good will at the local level.

THE PATIENT'S VIEWPOINT

Let me speak a word for the patient, a role I played in June when I went through an acute kidney stone attack. I wish the day might come when the patient would receive but one bill, or at least one package of bills delivered in the same envelope. I know it would be most difficult to implement, for some professional charges cannot be readily ascertained in full when the hospital makes up its final bill upon discharge. Yet, with good minds at work, some solution could be achieved.

Are we to cure the patient only to bombard him with a half-dozen separate bills? This scattering of bills is bad public relations when we need the best.

It would go hard with the lawyers if the client employing a great firm received a bill from Partner A for tax advice, a bill from Partner B for corporate reorganization, a bill from Partner C for labor relations conferences, and a bill from Partner D for appearances in court. It just wouldn't work.

So, as a patient and as a trustee, I would wish for that day when the doctors and the hospitals, having made a reasonable agreement as to compensation—whatever might suit on both sides—find a way to bill the patient once.

Visual aids to ease admitting

ROBERT H. LOWE, M.D.

"BUT NURSE, THAT isn't the kind of room I want!" exclaims the patient after the first view of his newly assigned hospital room. Back goes a relative to the admitting office to lodge a complaint, leaving the busy nurse on the unit trying to mollify the dissatisfied patient.

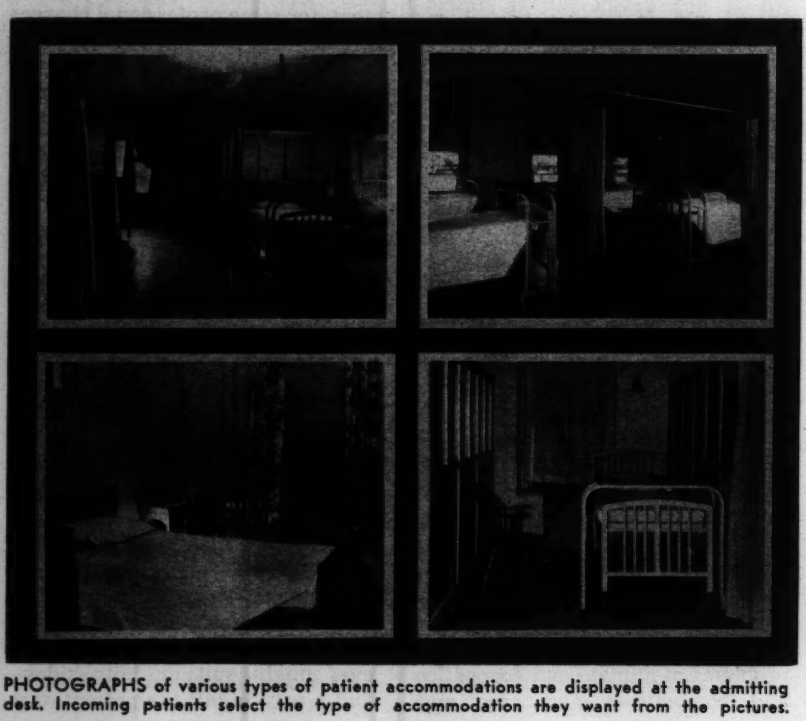
Dr. Lowe is administrator of Rochester (N. Y.) General Hospital.

The hospital stay is off to a bad start for all concerned, patient as well as employees. Work loads are increased, tempers shortened, patient and relatives disgruntled and the end man, the cashier, takes it in the neck trying to collect for something the patient emphatically insists he did not want.

An average of 43 patients are admitted daily to Rochester General Hospital. A little mental calculation will reveal the terrific problem we had from the operational point of view, to say nothing of what was happening to public relations, when we admitted patients who, upon seeing their rooms, became unhappy about their accommodations.

Our public relations director took up this problem. He reasoned that people can understand what they see and misunderstand what they hear; therefore, why not show them exactly what they are to receive at the time they enter the hospital? Pictures were taken by our medical photography department of the various types of patient accommodations: Private rooms, 2-bed rooms, and wards. These were placed, facing the patient, under the plate glass covering the top of the admitting officer's desk.

Under our new admitting system, the patient now sees what he is buying, the nurse on the unit greets a patient who knows what he is getting into, the cashier receipts the bill for what the patient knowingly accepted, and our public relations have taken a big step forward.



PHOTOGRAPHS of various types of patient accommodations are displayed at the admitting desk. Incoming patients select the type of accommodation they want from the pictures.

Remote control dictation system simplifies writing of records

MARJORIE R. QUANDT, B.A., R.R.L.

SURGICAL SECRETARIAL service once presented a continual problem at Wesley Memorial Hospital in Chicago. Because of a lack of available office space on the surgical floor of this 571-bed teaching hospital, one secretary working a 44-hour week handled dictation for an average of 35 operations a day, or an estimated total of 10,000 words a day. Qualified secretaries were unable to keep ahead on transcriptions of reports and on occasion they fell two to three weeks behind.

With only one employee taking dictation, surgeons had no incentive to dictate immediately after operating, but often would accumulate 30 or 40 reports. When these records were finally dictated, the tremendous increase in the normal work flow placed an additional burden on the secretary.

CHOOSING THE SYSTEM

Because of the scarcity of competent medical secretaries, the administration turned to mechanical dictation methods as a solution to the problem. This was a fairly drastic step as all but one surgeon avoided any available microphone-type dictating machine placed on the surgical floor for their use.

After studying various wire recorders, belt-type machines, and individual disc models, a remote control system was chosen. This employed an instrument familiar to any doctor since a specially adapted telephone was the dictating device.

Technicians from the manufacturer studied a series of 500 medical records for all types of reports written. From a line count of these reports, the technicians found that 37,629 words were written a day for all component parts of the records and that 10,000 of these were dictated for operative reports. With these figures, the hospital could judge the equipment necessary for a two-month trial of the system entailing only the cost of wiring the machinery.

This trial installation, which has become our initial system, consisted of one master writer with three telephone stations on the surgical floor and one in the medical record library, plus one transcriber. The company furnished all necessary discs and indexing slips for the two-month period. Special wires required were purchased through the manufacturer but installed by Wesley engineers. The actual hook-up of wires and machines was performed by the company's servicemen.

SIMPLE AND EFFICIENT

With the remote dictation system the secretary no longer works in close proximity to the operating rooms. The master writer and transcriber are placed in the medical record library two floors below. Three phones were placed on the surgical floor for the convenience of the surgical staff: One in the doctors' dressing room, another in the office formerly occupied by the secretary, and the third in a classroom. These were wired to the master writer along with the telephone in the record library.

An individual disc holds 36 minutes of dictation on its two sides. For simplicity of transcription, all like sides are cut before the discs are turned over and the opposite side used. The master writer is so constructed that the person dictating receives two warnings when he reaches the end of the 18 minute dictation period for one side of the disc. The first warning is a gentle ticking sound and this is followed by a steady hum if the dictator continues speaking. The secretary, in transcribing, is also warned of a completed disc by a loud buzz which is her signal to change the disc and index slip. This change is easily made in four or five seconds so that anyone requiring more time experiences little or no interruption of service.

The standard model French telephone, either wall or desk type, has been adapted as the individual dictating mechanism connected to the master writer. This phone enables any doctor to show length of report or a correction of content and even to listen to a 25-word playback by simply pressing designated buttons. The master writer records dictation whenever the "talk" switch is pressed on the handle of the telephone. Very little pressure is required to depress this button.

As soon as any phone is removed from its cradle, a red light flashes on at all stations, signifying a period of dictation. Should the doctor fail to note this "busy" light, he would hear the other person speaking. The master writer also has a light that works in conjunction with the stations to show that the equipment is in use.

FASTER SERVICE

Since its installation our equipment has been turned off only once. One of the advantages of this system is that it can be left running for indefinite periods of time, thus enabling doctors to dictate reports late at night when no secretaries are available. Periodic checks are made on the master writer by administrative personnel

Miss Quandt is director of the medical record department and school at Wesley Memorial Hospital, Chicago.

The Medical Review department is edited by Charles U. Letourneau, M.D., secretary of the Council on Professional Practice.

after the library closes in the evening to keep discs ready for dictation.

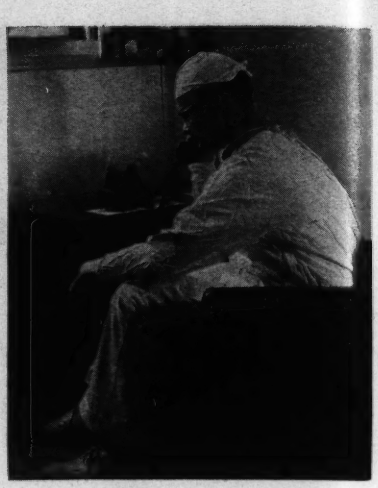
Despite longstanding opposition to machine dictation, the remote control system has been accepted with great enthusiasm by the attending staff and residents in completing operative reports. The secretary was flooded with dictation in the first 72 hours, but once the novelty wore off dictation tapered down until the work flow stabilized itself. Doctors no longer have to wait for an opportunity to dictate to the rushed secretary, and she in turn can now transcribe steadily without interruptions or delays. Reports are delivered to the floors sooner than those written under the previous arrangement.

ADDITIONAL EQUIPMENT

This trial proved so satisfactory that the equipment was purchased and plans were made for the expansion of the service to patient floors. This expansion will be a gradual one. Six phone stations are being added at this time—two on the obstetrical floor, two on the surgical floors, and two on the medical floors. The staff physicians, visiting patients on these units, will be able to dictate histories, reports on physical examinations, progress notes, and consultation reports by telephoning to the master writer in the medical record library. This addition to the service will require another master writer as well as a switchboard to enable maximum use of the 10 telephones placed throughout the hospital. All equipment will be periodically inspected through a yearly maintenance contract with the manufacturer.

It is expected that this new equipment and plan of record writing will necessitate the hiring of additional typists. In the past four months it has been evident that operative reports have become longer and more complete than those dictated prior to the installation. Already, three typists, working a total of 132 hours a week, are required to transcribe the surgical dictation. Two of these employees are experienced stenographers and the third is learning surgical terminology on the job. In periods of heavy dictation, and particularly during the weekends and holidays when no transcription is done, the stenographers may fall behind in work for a few days.

While the system is designed to prevent duplicate recording through the dual signal system of sound and light, double dictation has been received on certain discs. This, of course, is totally unintelligible and wastes the typist's time if she attempts transcription. This also means that the doctors involved must re-dictate their reports. The fault in this instance seems to rest more with a thoughtless dictator than with the machine. This has occurred only three times in approximately 3,000 dictation hours.



INSTALLATION of three telephones on the surgical floor cuts doctors' dictating time.

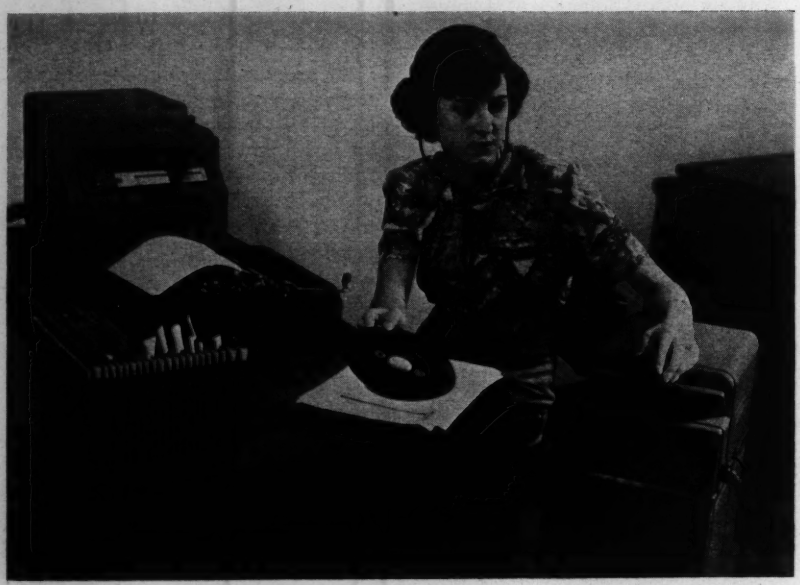
BENEFITS

Despite the initial expense, we feel that much is to be gained with a remote control dictation system. Instruction in use of equipment is extremely simple for all concerned. Doctors no longer put off writing their reports, and they can finish them quickly.

This saving for the attending staff permits more time for patient visits and instruction of house staff members. Residents and interns, too, can care for more patients when dictating the record takes only one-third the time required to write these records. Reports dictated to the master writer will be legible, more accurate, and complete.

A report on money saved cannot be given. This rather intangible advantage must be estimated for each institution, and it cannot be done unless stenographic rates, monthly stipends and maintenance of house staff, as well as the total work hours for each group, are known.

There is no doubt, however, that this system will enable better care of the patient through maximum use of professional skills, better written records, and compilation of excellent research data.



DICTATION is recorded on the master writer to the right of the typist. Transcriber and master writer are placed in the medical library two floors below the operating rooms.

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A new hospital laundry meets the test by paying its way

NORMAN D. BAILEY AND MORRIS FRIEDMAN

PLAN—EXECUTE—REVIEW: Such is the pattern for intelligent handling of any complex problem.

In 1946-47, Michael Reese Hospital (645 beds) faced the problem of a near-collapsing laundry operation. The plant was too small; equipment was outmoded and outworn, and employee facilities in the plant were inadequate. The result was excessive overtime labor, a generally unsatisfactory service, and heavy unbudgeted expenses for repairs or outside service by commercial laundries.

After weighing all factors involved, the board of directors and the administration were convinced that a new laundry would remedy most, if not all, of the troubles in the situation. So they had one built at a cost of about $450,000.

In an article published in HOSPITALS for March 1950, Dr. Morris H. Kreeger, executive director of the hospital, outlined the thinking behind the decision to go forward with the project. Now the time has arrived for a review of these objectives in relation to the accomplishments achieved.

A DETAILED ANALYSIS

It was believed that the turnover of employees could be reduced.

There had always been a nucleus of permanent employees in the hospital laundry. This is shown by the fact that eight employees out of a present total of 49 have been employed by the hospital for more than 10 years. There was a considerable area, however, where tenure of employment was very brief. The significant figure here is a reduction in turnover from 32 in the first six months of 1949 to 15 in the first six months of 1950. The first six months of 1951 show an increase to 23 which must be charged to the labor shortage caused by the opening up of defense jobs in industry. There is still an area of heavy turnover, but there is a noticeable reduction in the number of jobs in this area.

It was felt that if working conditions could be improved, not only would turnover be reduced but better employees would be attracted. Experience has borne out the prediction.

Personnel departments are aware that bad working conditions in laundries have turned away many possible workers. It did not take long for the news to spread that the new laundry at Michael Reese Hospital offered the best in working conditions. Clean, attractive workrooms with adequate ventilation, excellent rest rooms and showers, easy access to transportation lines, music during working hours—all of these helped bring the more desirable applicants to the hospital.

It is planned to change soon to a five-day week operation. This will aid in improving the morale of employees. The five-day week, however, cannot be operated on a Monday through Friday basis and will probably mean that the days off will be Wednesday and Sunday.

It was predicted that there would be a reduction in the total number of personnel employed.

A study shows that the laundry functions of 1948 utilized 64 employees. The same functions are being performed today by 44 employees. This has been the joint result of a more efficient plant and higher caliber employees.

The increase in production per worker is very significant.

In the old laundry, 53,000 pounds of laundry were handled weekly by 64 workers, an average of 828 pounds per week per worker.

In the new laundry, 58,000 pounds of laundry are cared for

ATTRACTIVE working conditions in the $450,000 Michael Reese Hospital laundry helped immeasurably in securing and keeping a competent group of employees.

Mr. Bailey is assistant administrator and Mr. Friedman is the laundry manager of Michael Reese Hospital, Chicago.

by 44 employees, an average of 1,318 pounds per week per worker. This represents an increase of 58 per cent.

It was believed that overtime and Sunday operation would be eliminated.

In 1948, overtime averaged nearly $1,000 a month. In 1951 this average has been reduced to approximately $30 a month. Sunday operations, other than pick-up of soiled linen, have been eliminated. One shift of workers is employed whereas two shifts were necessary in the old laundry operation.

The feeling that improved employee morale would result from the improved working conditions was amply justified.

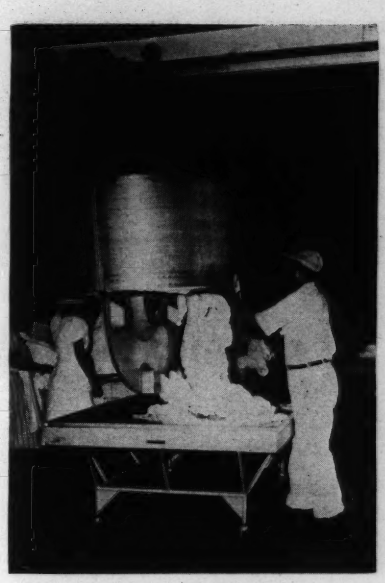
Installation of equipment for musical programs during working hours was expensive, but laundry work involves routine and repetitive tasks, and industry has found that the monotony of such tasks is relieved by music played at intervals. The Michael Reese Hospital laundry workers proved no exception to the rule. It is significant that, in a survey of workers made 18 months after the beginning of operation of the laundry, the following employee reactions to music were shown:

1. Ninety per cent of the employees like music with their work.
2. Ninety per cent feel that music makes the work easier and relieves monotony.
3. The majority of employees preferred music played at intervals rather than continuously.

Group activity of a social nature has developed. A dinner party sponsored by the employees at Christmas time, vacation time outings, and remembrances for ill or bereaved employees have all given evidence of a change for the better in the group attitude.

The new laundry was planned on the assumption that certain other operations could be assumed by the laundry. These operations were scattered throughout various hospital departments with a corresponding lack of uniformity in operation and control.

The first additional service to be brought under the laundry was employee uniform control. A perpetual inventory was set up, a one-for-one exchange system was instituted, and responsibility for mending uniforms was incorporated in the laundry process. The result has been (1) a reduction of more than 50 per cent in the loss of uniforms; (2) a reduction in the expenditure for replacements of uniforms in spite of a major rise in prices; (3) salvage of uniforms by prompt mending before the individual uniform is beyond repair, and (4) a neater, cleaner appearance among employees.



LABOR-SAVING equipment, like the overhead-type monorail extractor, allowed fewer employees to do a better job in less time.

Mending of linen had been performed in several places under different departments. Seamstresses now work adjacent to the place where flatwork comes off the ironers. Provision is made for immediate repair of all linen. The same repair plan holds for uniforms.

The reorganization made it possible to control the distribution of linen to the various departments directly from the linen room in the laundry. This control and distribution method has been introduced gradually and will eventually cover all linens.

Hand trucks designed to meet the requirements of the job of distribution have been ordered and, upon delivery, will facilitate the service.

Control of such items as dish towels, bed linen and hand towels has resulted in a reduction in losses due to carelessness, misuse, or theft.

It has been possible for the hospital's department of bacteriology to set up tests of the sterile conditions of items such as linens and dish towels.

A study of employee uniform design led to the adoption of a uniform that can be run through the flatwork ironer, thus saving the time and labor of hand pressing. This change made possible the ironing of eight uniforms in the time formerly taken to press a single uniform and, consequently, made it possible to provide more frequent changes.

Perhaps one other change should be mentioned. No longer is the shortage of available linen a perpetual headache to the administrative officers. The thought that the laundry may break down at any moment no longer haunts the administration. The amount of time that administrative officers have been compelled to give to laundry problems has been reduced to a minimum.

As would be expected in any new operation, "kinks" have developed which have had to be ironed out. At this writing a very few of these remain. The increased production per worker mentioned previously will be still further increased within the next six months. The linen stamping and sewing room for new linen which is still operated separately will be absorbed by the laundry. Complete delivery service directly to departments will soon be realized.

TWO NEW FUNCTIONS

Two new laundry operations have been made possible through successful experiment and modern equipment. These are the washing of rubber gloves and the washing of sponges.

The washing of gloves had been a separate operation performed in connection with the surgical supply unit. It was hoped that some means might be developed whereby this washing could be done in the regular laundry. After considerable experiment, the following technique was found satisfactory:

1. The gloves are given two flush rinses at 90°-100° F.
2. This is followed by a 10-minute suds bath with neutral soap.
3. Next, three flush rinses are given at 90°-100° temperature.
4. The gloves are then put in a

laundry bag and placed in the regular extractor for five minutes. (The use of the laundry bag rather than the usual mesh bag was found necessary. When gloves were placed loose in the extractor or enclosed in a mesh bag, the centrifugal force was great enough to suck the rubber through the perforations in the extractor. This caused blisters to appear on the gloves.)

5. The gloves are placed in a dry tumbler at 100° temperature for 20 minutes.

6. Powdering is done without turning the gloves inside out. With a machine developed for our own use, a four-dozen lot of gloves is powdered in from 10 to 15 minutes with resulting labor saving and increased satisfaction with results. In this process, it has been possible to eliminate the health hazard of inhaling the powder, to which employees were formerly exposed.

The problem of washing surgical sponges has been solved with increasingly satisfactory results and a reduction in labor cost. The sponges are placed in a rubber net to eliminate tangling and the loss of materials and time. The washing formula is as follows:

1. The sponges are given three cold rinses to remove blood and extraneous matter.

2. They are given a 10-minute soap and alkali wash at 120°-130° temperature.

3. This is followed by one hot rinse.

4. A 10-minute soap alkali and bleach wash is then given at 160°-180° temperature.

5. This is followed by one cold rinse.

6. The rubber net containing the sponges is then placed in the extractor for five minutes.

7. The sponges are then hung up for drying. A study is under way to speed up the process by mangle ironing.

SUMMARY

With excellent equipment and space for experimental work it should be possible to improve existing processes and to work out new solutions as time goes on.

From the point of view of financial savings, when all related factors are considered, the reduction in expenditure for operations amounts to 20 per cent in salary budget. Expenditures for supplies and materials have not risen proportionately with the increase in production.

Visits from other administrators and laundry managers have become frequent occurrences. Michael Reese Hospital welcomes these visitors and is glad to be of any service it can to them.

LAUNDRY MANAGEMENT COMMENT

Calendar for education

TWO EDUCATIONAL PROGRAMS for laundry managers are now on the Association calendar. The first is the five-day institute being conducted this month in Boston, and the second is the seven-week hospital laundry management training course to be held early next spring at the State University of Iowa.

This month: Applications are still being accepted for the Institute on Hospital Laundry Management being conducted at Boston's Somerset Hotel, Nov. 26-30. (This meeting was formerly scheduled for the Kenmore Hotel.)

Instructions for enrolling in the institute have been mailed to all Association members. The tuition fee is $35 and covers the full cost of the educational program. Students make their own rooming arrangements with the hotel, and a form for this purpose is provided with the application blank.

Registration will take place Monday, Nov. 26, in the Princess Ballroom of the Somerset Hotel.

Next spring: As a result of the outstanding success of the Hospital Laundry Management Training Course conducted at the State University of Iowa early in 1951, there are definite plans for a similar course in 1952 at the same location. This year the course will open on March 10 and close on April 25.

The last course, conducted from Feb. 12 to March 30, 1951, met enthusiastic acclaim from all participants, who traveled to Iowa City from 17 states and Canada.

Chief among the reasons for the popularity of the course was its thorough approach to the problems of institutional laundering. During the seven-week period, students attended 214 hours of lectures, conferences, motion pictures and laboratory work—all dealing with practical problems likely to be encountered by the hospital laundry manager.

In addition, each student took home one of the most complete assemblages of institutional laundry information ever compiled, consisting of his own notes, complete outlines of all lectures, and a 12-inch stack of selected commercial literature.

This year, as last, the American Hospital Association is making available 10 scholarships to the course through the sponsorship of Pacific Mills (textile manufacturer). Each scholarship will be for $275, and should cover a substantial portion of the winning student's expenses.

In certain instances, the course is approved for veterans training under Public Law 346. Applicants who believe they might be eligible for enrollment under this bill should write for particulars to the Veterans' Service Office, 110 Iowa Avenue, Iowa City.

Further information regarding application for the course and for scholarships will be mailed out by the Association this month.

Readers of this department are invited to send in questions, problems, and solutions to problems involved in effective operation of the hospital laundry. Queries will be channeled to appropriate authorities for answers. Where the material is of general interest, portions of it may be published. Address all correspondence to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10.

Cooperative planning of dietary services for 50 to 200-bed general hospitals

THE DIETARY service is an important part of the hospital team, and it has that team's goal as its objective—to provide better patient care through efficient operation.

If better patient care is to be achieved, each department must first determine its responsibilities and functions. Aside from the clinical responsibilities to the patients, the functions of the dietary department, administratively, are these:

1. To serve appetizing and nourishing meals to patients.

2. To serve appetizing and nourishing meals to personnel caring for the patients.

3. To provide this food as economically and efficiently as possible.

Successful discharge of these responsibilities depends upon careful planning of the layout and equipment and upon adequate and well trained personnel. Important factors to consider in planning and equipping a kitchen, in addition to proper size, type, quality and arrangement of equipment, are sanitation, equipment maintenance, cost of operation and the kind and number of staff that will be needed. The comfort and safety of all workers is also a major consideration. Good planning will insure that the flow of work within and between each unit can proceed without loss of time.

These goals in kitchen planning can rarely be attained without the cooperative efforts of many professional groups: The architect, the dietitian, the administrator and the mechanical, sanitary, construction, and electrical engineer. The plans presented (figures 1, 2, 3) are the result of the cooperative planning of representatives of these professions.*

The first task was to determine the best place for the main kitchen. The kitchen should be at or above grade level to eliminate any complications with sewage and to assure adequate outside light and ventilation. It should be convenient to the elevators leading to the patient area and convenient to the outside loading area.

The kitchens shown on these pages have been placed at the end of a wing of the hospital. This eliminates much undesirable traffic in the kitchen and allows some deliveries to be made directly to the kitchen storage area. Adjoining this area at the receiving entrance is a dock platform for unloading purposes.

The dining room or cafeteria is across the hall from the kitchen in the 50-bed plan and adjacent to the kitchen in the 100- and 200-bed plan. This permits considerable utilization of outside light from the side windows.

After the area had been designated for the kitchen there were several questions that had to be answered and certain basic assumptions to be made before the plans could be developed further. We do not wish to indicate that the food service practices which influenced our decisions are the *only* good methods, but they represent what we feel is a practical solution and are representative of the practices that may be followed in general hospitals of 200 beds or fewer. Four major questions were explored before any drawing was undertaken.

1. Who is to be fed and what will be the average number of meals served? (Answers in tables 1 and 2, on pages 86 and 89.)

2. How, where and when are patients and personnel to be served?

A. Patient Service: The question of tray service deserves special consideration. To reduce the need for supervisory personnel and with the distance between kitchen and patient comparatively short, a plan somewhere midway between centralized and decentralized tray service was selected. This we have termed "centralized bulk food service."

The trays are set up centrally in the kitchen with a tray cover, salt and pepper, napkin, silverware, cup and saucer and glass. Plates are placed in the warming section of the food conveyor. The cold dishes such as salads and desserts may be portioned out in the kitchen and kept in the refrigerators until meal time. These may be transported in the unheated section of the food conveyor or placed on the trays immediately before leaving the kitchen. If the latter practice is followed, an enclosed type of tray truck should be used.

The bulk food is transported to the different floors at meal time in electrically heated conveyors. The beverages are sent in vacuum or insulated containers. Food conveyors are plugged into an electrical outlet on the corridor wall at a convenient place within the patient area but out of a direct line

Prepared by: Wilbur R. Taylor, hospital architect; Miriam Kaufman, dietary equipment consultant; Edith A. Jones, dietitian consultant; under the general direction of John W. Cronin, M.D., chief, Division of Hospital Facilities, Public Health Service, Federal Security Agency.

* See acknowledgements.

KITCHEN FOR A 50-BED GENERAL HOSPITAL USING CENTRALIZED BULK FOOD SERVICE

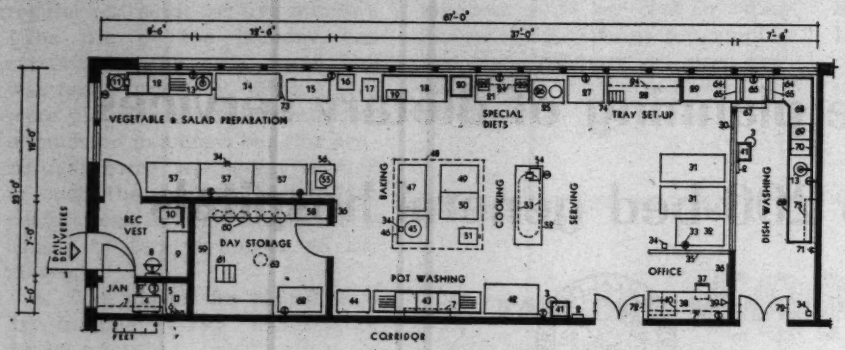


Fig. 1

Note: If food waste grinders are not used, garbage refrigerator and can washing room should be provided.

1. Screen door
2. Paper towel cabinet
3. Waste paper receptacle
4. Mop truck
5. Curb and receptor or sink
6. Mop rack
7. Shelf over
8. Hanging scale with pan, dial face, 60 lb. x 1 oz.
9. Counter, for checking deliveries
10. Platform scale
11. Peeler, 15 lb. capacity, pedestal type with peel trap
12. Double compartment sink, each compartment 24 x 24 x 14", one drainboard
13. Food waste grinder, institutional size, with pre-rinse spray
14. Preparation table, 30 x 72", with 2 drawers and undershelf
15. Utility truck
16. Water cooler
17. Cooling rack, 24 x 18 x 72", on casters
18. Baker's table, 30 x 72" with 2 drawers and over shelf
19. Baker's scale
20. Single compartment sink, 24 x 24 x 24"
21. Counter, 30 x 60", cabinets below
22. Dietetic scale, gram
23. Toaster, electric, 4 slice, heavy duty
24. Wall cabinets
25. Coffee urn stand
26. Coffee urn, (battery), one 5 gal. coffee urn, one 10 gal. boiler
27. Ice cream cabinet, 15 gal. capacity. Provide running water dip well if bulk ice cream is used
28. Counter 30 x 84" open shelves below
29. Clean dish table with up-turned edge
30. Glass partition above wainscot
31. Tray truck, open, approximately 25 tray capacity (tray size approximately 14 x 18")
32. Food conveyor, 50 patient capacity
33. Electric outlet
34. Floor drain
35. Partition 3 ft. high
36. Bulletin board, 26 x 24"
37. Straight chair
38. Built-in desk
39. Telephone outlet
40. File cabinet, 2 drawer
41. Lavatory, (hand washing)
42. Refrigerator, (salad and cook's), 40 cu. ft. capacity
43. Three compartment sink, each compartment 24 x 24 x 14", one compartment with dial thermometer, two drainboards
44. Pot cabinet, 24 x 36 x 72", adjustable open shelving, on casters
45. Kettle, steam jacketed, 10 gal. capacity
46. Floor depression
47. Roasting oven, two sections, each with additional removable shelf for baking (deck 33 x 22")
48. Hood
49. Range, oven below
50. Range, one section griddle, and one section hot top, broiler below
51. Steamer, one bushel capacity
52. Cook's table, 30 x 90", with plate warmer
53. Pot rack, over cook's table
54. Meat slicer, motor driven
55. Mixer, bench type, 20 qt. capacity with 12 qt. bowl, meat and food chopper attachments
56. Cabinet stand for mixer
57. Refrigerator, 40 cu. ft. capacity
58. Locker cabinet
59. Shelves, 16" deep, first shelf 36" from floor
60. Storage can, mounted on casters
61. Step ladder, pantry type
62. Frozen food cabinet, vertical type, 18 cu. ft. capacity
63. Ventilator at ceiling
64. Hood
65. Dish table drain
66. Dishwashing machine, single tank, floor model, vertical sliding door, approximate capacity 1,250 pieces per hour, automatically timed
67. Rack return
68. Soiled dish table with 3" up-turned edge
69. Double compartment soak sink
70. Slide rails, (for conveying dish racks)
71. Hot and cold water outlet
72. Vision panel
73. Kitchen tool rack
74. Silver box, 4 compartment
75. Shelf over for soiled glasses

of traffic. The tray trucks, with trays, are moved from the main kitchen to the patient area at the same time. As each tray is completed, it is carried immediately to the patient. The trays are collected after use and returned on the tray truck to the dishwashing room with the dishes on them.

This type of service offers the economy of centralized dishwashing, thus eliminating the duplication of equipment and services in the floor pantries. It makes it possible for the dietitian to keep a close check on her food service and on the popularity of the foods served. This system also permits better supervision of personnel.

B. Personnel service: In the 100- and 200-bed hospital where large numbers of personnel are served, cafeteria service is planned. All the food for the cafeteria would be prepared and transported from the main kitchen.

In the 50-bed hospital the number of personnel to be served at any one time during the meal period is small. For this reason they are to eat in a dining room with waitress service. The plates are served directly from the cook's table in the kitchen.

C. Meal service period: The size, capacity, and type of equipment must be determined not by the total number of persons served, but rather by the total number of persons served at one time. Thus the *time of meal service* has a direct bearing on the planning. The meal periods for patients and personnel usually will overlap at noon and often at breakfast. The maximum amount of food that will have to be prepared for any one time will be a quantity to serve all patients and approximately one-third of the personnel. In all three plans, we have determined that the patient's meal hour will extend over a 30 to 45 minute period and probably will overlap 15 to 20 minutes of the personnel meal service at noon. Personnel meal hours would extend over a period of 1 to 1½ hours. This would mean that food will have to be replenished in the cafeteria at least once during the serving period.

TABLE 1

Maximum number of persons to be fed

	50-Bed	100-Bed	200-Bed
Patients	50	100	200
Personnel[1]	75	150	300
Total	125	250	500

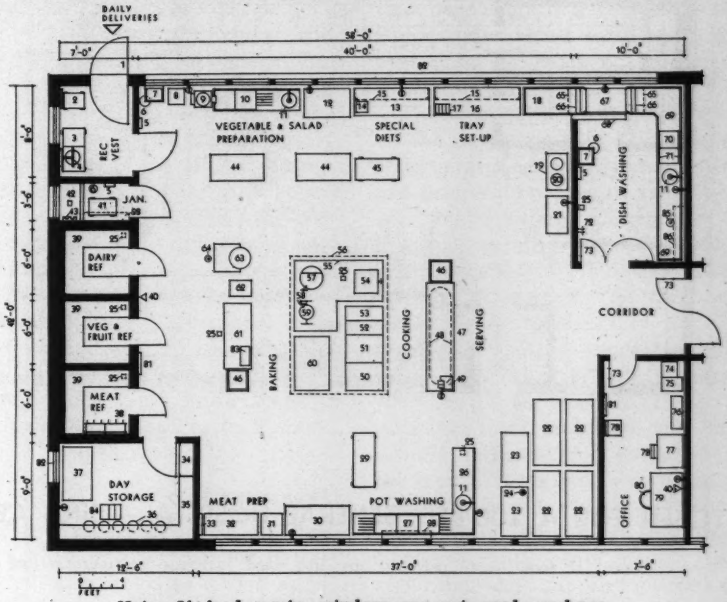
[1] Based on ratio of 1.5 personnel per patient.

3. What menus will be served?

It was assumed that personnel in the 50-bed hospital would be served the same menu as the pa-

KITCHEN FOR A 100-BED GENERAL HOSPITAL USING CENTRALIZED BULK FOOD SERVICE

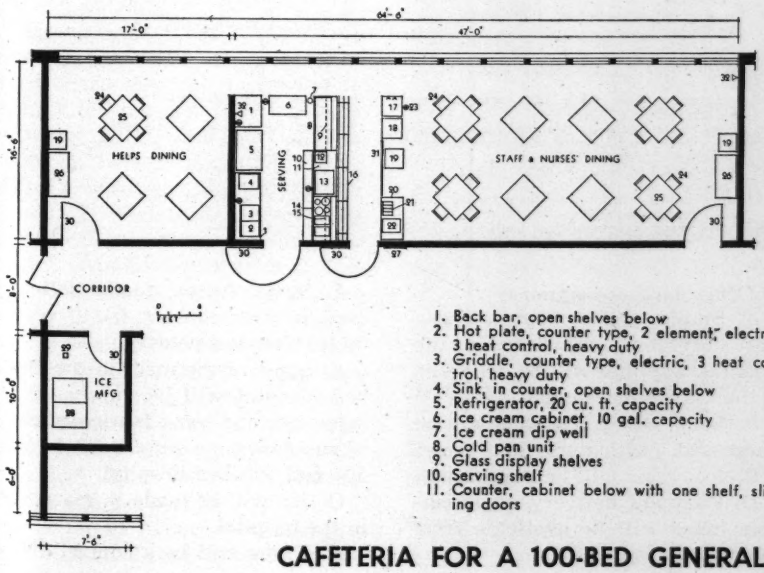
1. Screen door
2. Platform scale, 1,000 lb. capacity, drop lever
3. Platform truck
4. Hanging scale with pan, dial face, 60 lb. x 1 oz.
5. Paper towel cabinet
6. Waste paper receptacle
7. Lavatory (hand washing)
8. Water cooler
9. Peeler, 30 lb. capacity, pedestal type with peel trap
10. Double compartment sink, each compartment 24 x 24 x 14", one drainboard
11. Food waste grinder, institutional size, with pre-rinse spray
12. Refrigerator (salad) 30 cu. ft. capacity
13. Counter, 30 x 84", cabinets below
14. Dietetic scale, gram
15. Wall cabinets
16. Counter, 30 x 96", open shelves below
17. Silver box, 4 compartments
18. Clean dish table with up-turned edge
19. Coffee urn stand
20. Coffee urn (battery) one 5 gal. coffee urn, one 10 gal. boiler
21. Ice cream cabinet, 10 gal. capacity. Provide running water dip well if bulk ice cream is used.
22. Tray truck, open, approximately 25 tray capacity (Tray size approximately 14 x 18")
23. Food conveyor, 50 patient capacity
24. Electric outlet, ceiling drop, 2 receptacles
25. Floor drain
26. Table with up-turned edge
27. Three compartment sink, each compartment 24 x 24 x 14", one compartment with dial thermometer, two drainboards
28. Shelf over
29. Pot cabinet, 24 x 60 x 72", adjustable open shelving, on casters
30. Refrigerator, (cook's), 50 cu. ft. capacity
31. Meat block
32. Table, 24 x 60"
33. Kitchen tool rack
34. Locked cabinet
35. Shelves, 16" deep, first shelf 36" from floor
36. Storage can, mounted on casters
37. Frozen food cabinet, vertical type, 30 cu. ft. capacity
38. Meat hooks and rail
39. Refrigerator shelving, 18" deep, first shelf 36" from floor
40. Telephone outlet
41. Mop truck
42. Curb and receptor or sink
43. Mop rack
44. Preparation table, 30 x 60", with drawer and under shelf
45. Utility truck
46. Single compartment sink, 24 x 24 x 14"
47. Cook's table, 30 x 120", with 2 drawers and undershelf
48. Pot rack over cook's table
49. Meat slicer, motor driven
50. Range, oven below
51. Range, broiler below
52. Spreader plate



Note: If food waste grinders are not used, garbage refrigerator and can washing room should be provided.

Fig. 2

53. Deep fat fryer, approximately 25 lb. capacity
54. Steamer, 2 compartment, 4 bu. capacity
55. Floor depression
56. Hood
57. Kettle, steam jacketed, 30 gal. capacity
58. Swinging water spout over steam kettle (hot and cold water)
59. Kettle, steam jacketed, trunnion, 10 gal. capacity
60. Roasting oven, two sections, each with additional removable shelf for baking (deck 42 x 32")
61. Baker's table, 30 x 72", with 2 drawers and overshelf
62. Cooling rack, 24 x 18 x 72", on casters
63. Mixer, 60 qt. capacity, with 30 qt. bowl, meat and food chopper attachments
64. Electric outlet at floor
65. Hood
66. Dish table drain
67. Dishwashing machine, single tank, floor model, vertical sliding door, approximate capacity 3,000 pieces per hour, automatic
68. Rack return
69. Soiled dish table with 3" up-turned edge
70. Double compartment soak sink
71. Slide rails, (for conveying dish racks)
72. Hot and cold water outlet
73. Vision panel
74. Locker
75. File cabinet
76. Bookcase
77. Table, 30 x 36"
78. Straight chair
79. Desk
80. Swivel chair with arms
81. Bulletin board, 26 x 24"
82. High windows
83. Baker's scale
84. Step ladder, pantry type
85. Glass washing brush
86. Shelf over for soiled glasses

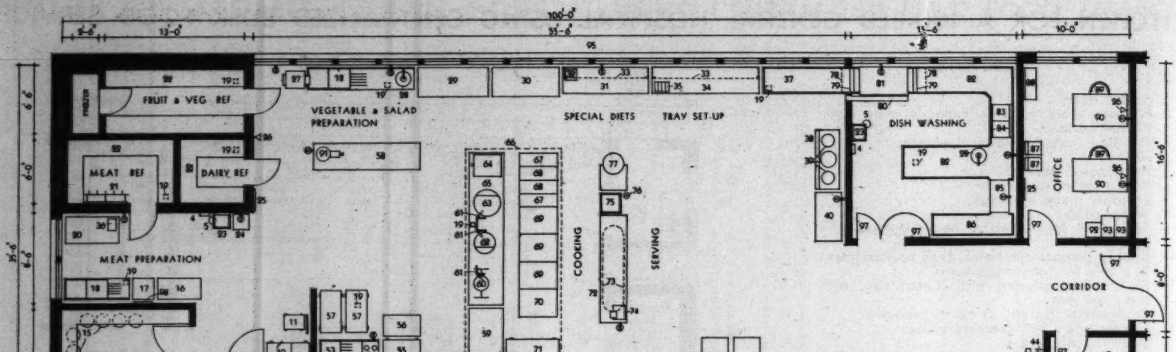


1. Back bar, open shelves below
2. Hot plate, counter type, 2 element, electric, 3 heat control, heavy duty
3. Griddle, counter type, electric, 3 heat control, heavy duty
4. Sink, in counter, open shelves below
5. Refrigerator, 20 cu. ft. capacity
6. Ice cream cabinet, 10 gal. capacity
7. Ice cream dip well
8. Cold pan unit
9. Glass display shelves
10. Serving shelf
11. Counter, cabinet below with one shelf, sliding doors

Fig. 4

12. Toaster, electric, 4 slice, heavy duty
13. Coffee maker, vacuum type, 5 elements
14. Hot food table with interchangeable panel inserts, and dish warmer below
15. Shelf and glass protector panel
16. Tray slide
17. Water cooler
18. Glass rack
19. Folding tray stand
20. Table, 24 x 48 x 30" high
21. Silver box, 4 compartment
22. Trays (approximately 14 x 18")
23. Electric outlet at floor
24. Dining chair
25. Dining table, 36" square
26. Tray truck, open
27. Menu board
28. Ice making machine
29. Floor drain
30. Vision panel
31. Railing
32. Telephone outlet

CAFETERIA FOR A 100-BED GENERAL HOSPITAL



KITCHEN FOR A 200-BED GENERAL HOSPITAL USING CENTRALIZED BULK FOOD SERVICE

Note: If food waste grinders are not used, garbage refrigerator and can washing room should be provided.

Fig. 3

1. Screen door
2. Counter, for checking deliveries
3. Hanging scale with pan, dial face, 60 lb. x 1 oz.
4. Paper towel cabinet
5. Waste paper receptacle
6. Mop truck
7. Shelf over
8. Curb and receptor or sink
9. Mop rack
10. Platform truck
11. Platform scale, 1,000 lb. capacity, drop lever
12. Locked cabinet
13. Shelves, 16" deep, first shelf 36" from floor
14. Step ladder, pantry type
15. Storage can, mounted on casters
16. Table, 24 x 48", on casters
17. Meat block
18. Double compartment sink, each compartment, 24 x 24 x 14", one drainboard
19. Floor drain
20. Preparation table, 30 x 60", with drawer and undershelf
21. Meat hooks and rail
22. Refrigerator shelving, 18" deep, first shelf 36" from floor
23. Lavatory, (handwashing)
24. Water cooler
25. Bulletin board, 26 x 24"
26. Telephone outlet
27. Peeler, 30 lb. capacity, pedestal type with peel trap
28. Food waste grinder, institutional size, with pre-rinse spray
29. Refrigerator, (salad), 60 cu. ft. capacity
30. Refrigerator, (cook's), 50 cu. ft. capacity
31. Counter, 30 x 96", cabinets below
32. Dietetic scale, gram
33. Wall cabinets
34. Counter, 30 x 120", open shelves below
35. Silver box, 4 compartment
36. Meat chopper, 8 lb. per minute capacity
37. Clean dish table, with up-turned edge
38. Coffee urn stand
39. Coffee urn, (battery) two 5 gal. coffee urns, one 10 gal. boiler
40. Ice cream cabinet, 20 gallon capacity. Provide running water dip well if bulk ice cream is used
41. Food conveyor, 50 patient capacity
42. Electric outlet, ceiling drop, 4 receptacles
43. Tray truck, open, approximately 25 tray capacity (tray size approximately 14 x 18")
44. Hot and cold water outlet
45. Three compartment sink, each compartment 24 x 24 x 14", one compartment with dial thermometer, two drainboards
46. Proof box, 24 x 30 x 72"
47. Cooling rack, 24 x 18 x 72"
48. Mixer, (bench type), 20 qt. capacity, with 12 qt. bowl
49. Cabinet stand for mixer
50. Baker's table, 30 x 72", with two drawers and overshelf
51. Baker's scale
52. Refrigerator, 20 cu. ft. capacity
53. Single compartment sink, 24 x 24 x 14", one drainboard
54. Two element hotplate flush with counter top, (for baker)
55. Pot cabinet, 24 x 42 x 72", adjustable open shelving, on casters
56. Counter, bread storage cabinet below
57. Utility truck
58. Preparation table, 30 x 120", with drawer and undershelf
59. Oven, three sections, two sections baking, one section roasting with additional removable shelf, (deck 42 x 32")
60. Kettle, steam jacketed, trunnion, 10 gal. capacity
61. Swinging water spout over steam kettles (hot and cold water)
62. Kettle, steam jacketed, 30 gal. capacity
63. Kettle, steam jacketed, 60 gal. capacity
64. Steamer, three compartment, 6 bu. capacity
65. Floor depression
66. Hood
67. Spreader plate
68. Deep fat fryer, approximately 25 lb. capacity
69. Range, oven below
70. Broiler, double deck
71. Pot cabinet, 24 x 60 x 72", adjustable open shelving, on casters
72. Cook's table, 30 x 120", with 2 drawers and undershelf
73. Pot rack over cook's table
74. Meat slicer, motor driven
75. Single compartment sink, 24 x 24 x 14"
76. Electric outlet at floor
77. Mixer, 60 qt. capacity, with 30 qt. bowl
78. Hood
79. Dish table drain
80. Rack return
81. Dishwashing machine, single tank, approximate capacity 4,500 pieces per hour, automatic
82. Soiled dish table, with 3" up-turned edge
83. Double compartment soak sink
84. Slide rails, (for conveying dish racks)
85. Glass washing machine
86. Dish table with up-turned edge (for clean glasses)
87. Straight chair
88. Bookcase
89. Swivel chair with arms
90. Desk
91. Food cutter, bowl 15" diameter
92. Locker
93. File cabinet
94. Ice making machine
95. High windows
96. Table with up-turned edge
97. Vision panel
98. Kitchen tool rack

tients on the normal diet. Those served in the cafeteria of the 100- and 200-bed hospitals would have a choice of some items. Menus for the normal and special diets which follow the principles of planning special diets as a modification of the basic hospital diet, served as a guide in the planning.*

4. Other basic assumptions:

A. Staples will be kept in a central storeroom elsewhere in the hospital. Supplies will be delivered to the kitchen once a day.

B. Some baked products will be purchased, particularly loaf bread.

C. Ice cream will be purchased.

D. Frequent delivery of perishable items will be available from the community

E. Some frozen foods will be used, including meats, fruits, vegetables, fish and poultry.

F. Some of the meat in the 200-bed hospital will be purchased in large cuts and some fabricated cuts of meat will be purchased in the 50- and 100-bed hospital.

G. Ice will be made in machines in the hospital.

H. There will be a central dish-

* Master Menu published monthly in HOSPITALS.

washing room for patient and personnel dishes. Dishes from isolated patients will be sterilized in the self-contained isolation nursing unit. Where separate contagious wards or tuberculous wards are maintained, this particular floor will have its own dishwashing unit.

I. In the 50-bed hospital, the total staff on duty each day in the dietary department will be approximately seven persons; in the 100-bed hospital, approximately 12 persons.[9] (The staff of the 200-bed hospital may be more than twice the number indicated for the 100-bed hospital. The equipment and layout planning affects the number of employees that will be needed. For example, in the small hospital it is necessary to save steps for the cook so as to allow her to perform and watch several operations at one time.)

J. In the three plans presented, no space has been allotted for teaching of student nurses within the kitchen area.

K. The formula room has not been included as part of the main kitchen.

L. Each floor pantry will be equipped with a sink, a heating unit where small between-meal nourishments could be prepared, and a refrigerator where fruit juices and other foods for nourishments can be stored. The floor pantry will not be used for patient tray service. All dishes used in the floor pantry will be returned to the central dishwashing unit for cleaning and bactericidal treatment.

Having determined this basic information we still had to bear in mind some general factors. The main kitchen must function as a complete unit. Each part of the main kitchen is so inter-related that it is necessary to plan the flow of work so that food will move in one direction to patients and personnel without backtracking. The basic sequence of *receiving* to *storage* to *pre-preparation* to *preparation* to *serving* and to *consumption* applies in all kitchens regardless of size. Also, for efficient operation, areas for the disposal of waste, pot washing and office space must be provided. Toilet and locker facilities should be near by.

One might expect that the size of a kitchen would increase in direct ratio to an increase in patient beds. This is not true, since the same basic operations must be performed in all hospital kitchens. The minimum amount of space for these operations is considerable and will not double with a proportionate increase in patient beds. For example, in the 50-bed hospital plan the dietary facilities cover a net area of 1,540 square feet. The 100-bed plan has a net area of approximately 2,435 square feet, and the 200-bed plan has an approximate net area of 3,550 square feet.

To understand the planning for each of the units within the three kitchens, one must know exactly the operations that are to be performed in each area:

RECEIVING AREA

In the receiving area, enough space must be provided for deliveries of such items as crated eggs, oranges, milk or lettuce. This area should be so situated that foods can be moved to the storage area in the kitchen on carts by the most direct route without obstruction.

The receiving area must be large enough to accommodate a platform scale for checking deliveries of large items, and a hanging scale for the smaller items. Where space permits, a counter has been provided to facilitate the checking of deliveries. In the 100- and 200-bed plan, a platform truck has been provided for transporting the large deliveries. In the 50-bed hospital, deliveries should be of such nature that a small utility truck is adequate.

STORAGE

A. *Day storage:* Provision of a day storage area is based on the assumption that a central storeroom will be maintained and staples will be issued by a storekeeper for current use. The day storage area accommodates small food items and part cases of foods not requiring refrigeration.

The most convenient place to set up the day storage is near the receiving area and adjacent to the pre-preparation area of the kitchen. This location is important so that food supplies may be handled and controlled in the most efficient manner. It may not be the most accessible for delivery of supplies from the central storeroom, but deliveries from the central storeroom to the kitchen probably will not occur more than once each day, usually in the early morning before the food preparation is under way.

Vermin-proof storage cans on casters have been placed in the day storage for dry beans, sugar, flour and other dry supplies purchased in large quantities. A locked cabinet is provided for storage of some small items. Adjustable open shelving has been used in the day storage so that all storage space can be used to the best advantage and the need to store food on the floor is eliminated. To facilitate handling and selection of food, a step ladder has been provided.

It is suggested that bread can be stored in this area also. If so, additional precautions must be taken to prevent vermin attack. Bread can be stored in a bin under the tray setup counter, or under the special diet counter. The same principles of rat-proofing would apply in these areas.

In the 200-bed hospital, a separate cabinet has been provided for bread storage. This location, adjacent to the baking area is convenient to receiving also.

TABLE 2

Maximum meals to be served—average[1]

	50-Bed		*100-Bed*		*200-Bed*[2]	
	Patients	Personnel	Patients	Personnel	Patients	Personnel
Breakfast	50	20	100	70	200	140
Lunch	50	55	100	100	200	200
Supper	50	20	100	75	200	150
Night meal	----	----	------	----	------	------

[1] Personnel number determined from "Staffing the General Hospital—25 to 100 Beds," Schafer, Margaret K.[9]
[2] Estimated figures.

B. *Refrigeration storage:* In the 200- and 100-bed plan, three walk-in refrigerators are located so that perishable foods can be delivered and stored conveniently. They are arranged so that they are accessible to all preparation areas. These have been planned for the storage of meat, milk and vegetables. The meat refrigerator is provided with meat hooks and rails and adjustable shelving.

In the 50-bed plan, three 40-cubic feet reach-in refrigerators have been planned for storage of meat, milk and vegetables. These too are fitted with adjustable shelving and are adequate for small hospitals in areas where deliveries are frequent. In some cases, however, where hospitals are in isolated areas, walk-in refrigerators will be essential to provide storage space for infrequent deliveries.

Additional reach-in refrigerators are provided in units of the kitchen where especially needed for the cook's use, for salads, for special diet foods or for desserts.

C. *Frozen food storage:* Since frozen foods are widely used in institutional food service, we have tried to anticipate a sufficient amount of storage space for frozen food. In the 200-bed plan, a frozen food locker has been provided at the back of the vegetable walk-in refrigerator. The capacity of this locker is approximately 80 cubic feet. This has been placed so that there would be a direct flow of frozen food to the vegetable and salad pre-preparation unit.

The quantity of frozen food that will be used by the 100- and the 50-bed hospitals will be smaller in proportion to that of the 200-bed hospital. Frozen food storage cabinets have been placed in the day storage area of the 100- and 50-bed hospital plans, their capacity being 30 and 18 cubic feet respectively. Storage for ice cream has been provided in the serving area.

JANITOR'S CLOSET

This unit has been placed near the kitchen area so as to have the necessary cleaning supplies convenient and easily accessible. In these plans the janitor's closet has been situated so there would be outside ventilation and natural light available. Each janitor's closet has been equipped with a curb and receptor or sink, a mop truck, and a mop rack. Floor drains have been planned throughout the kitchen area to facilitate the flushing and mopping of the kitchen floor.

PRE-PREPARATION

A. *Vegetable and Salad:* The preliminary preparation of vegetables and fruits involving sorting, washing and peeling and cutting food before it is sent to the cook's unit or prepared as salad or dessert. In these plans, vegetable and salad preparation have been combined and work table space has been provided for completing salad preparation. The salads are to be stored in the refrigerator adjacent to this unit. In the 50-bed plan, the refrigerator's location makes it convenient for the waitress to serve salads and desserts and other refrigerated foods to the dining room across the hall.

Provision has been made for adequate floor space in this unit for storing vegetables and fruits in sacks and crates. Aisles five to seven feet wide have been allowed for more efficiency whereas three- to four-foot aisles suffice for other units.

The quantity of vegetables and fruits that will be prepared in this area is large in the 200-bed hospital. A motor-driven food cutter has been provided to assist with the pre-preparation. Only one potato peeler (30-pound capacity) has been placed in this unit on the basis that there will probably be one employee assigned fulltime to this area. The potato peeler is placed so that it empties directly into the two-compartment sink. All sinks shown in these plans, with the exception of the one in the dishwashing area, are 24 x 24 x 14 inches and have a 12-inch splash-back. A food waste grinder has been installed in the drainboard of the sink in this area.

By the use of food waste grinders the problems of vermin control are simplified somewhat. A food waste grinder also eliminates the odors and seepage that so often occur when refuse is collected in cans. An effort has been made to place a food waste grinder in the area where food waste occurs, so as to avoid the transportation of refuse.

With the use of the food waste grinder, galvanized refuse cans on casters must be provided for the collection of paper, bottles and cans. The trash collection area is not shown, but should be conveniently situated on or adjacent to the loading platform.

If food waste grinders are not used some provision must be made for food waste storage, preferably a refrigerated room. An adjacent room equipped with warm water and steam outlets, is necessary also for can washing.

The smaller hospital (the 100- and the 50-bed) requires the same equipment as the 200-bed hospital for vegetables and salad preparation. In the 50-bed plan, a peeler of 15-pound capacity should be adequate.

B. *Meat:* In the 200-bed hospital the meat pre-preparation unit is equipped with a table, meat block, sink and meat chopper. A double compartment sink has been provided so that cutting equipment can be washed adequately. If the hospital has an unusually large amount of meat, fish and poultry to prepare, then consideration should be given to the installation of a food waste grinder.

In the smaller hospital, the cook or cook's helper will perform the meat-cutting jobs. In the 100-bed hospital the work load is sufficient to warrant the need for a meat block and a table for use in the preparation of meat. In the 50-bed hospital, no special equipment has been planned for meat cutting.

PREPARATION

A. *Baking:* In the 200-bed plan, a central baking unit has been equipped with a 20-quart mixer, a table, sink, proof box, cooling rack, pot cabinet with open shelving, and a counter top with a recessed two element heating unit. It was decided that the amount of baking in the 200-bed hospital would not require a separate oven for baking. Consequently, the three-section oven is placed with the other equipment convenient to the baking unit. The roasting section of the oven has an additional shelf that, when needed, can serve as a baking oven.

It is generally agreed that in the institutions of 100- and 50-bed capacity, the volume of baking and the limited staff does not justify the provision of a separate baking unit. In these the assistant cook probably will do all the baking. The two section roasting oven has been located with the other cooking equipment. These ovens are equipped with additional shelves so that each section can be used for baking. A cooking rack has been provided to add working space for the cook in the 50- and 100-bed plans. The mixer, and other equipment which might be used in baking have been centrally situated.

B. *Cooking:* In the 200-bed plan the cooking unit has been placed so that the vegetables and other foods can move directly from their prepreparation unit to be cooked and directly from preparation to the cook's table which will be the center of the serving area The three-compartment steamer has been placed close to the vegetable prepreparation unit. Three steam jacketed kettles of different sizes have been provided. Two small deep-fat fryers were selected in preference to one large one, and a double deck self-contained broiler is placed directly behind the cook's table. A mixer for the main kitchen's use is in front of the cooking unit. This is a convenient location for mashed potatoes to be prepared and served directly. Three ranges with oven space below complete this cooking unit.

The equipment in the cooking unit of the 100-bed plan has been planned for the same general area as in the 100-bed plan. A two-section roasting oven has been provided, with each section equipped with an additional shelf so that it can be converted to use for baking. In the 100-bed plan there is limited need for steam jacketed kettles. This kitchen is equipped with one 30 gallon steam-jacketed kettle and one 10-gallon trunnion kettle. These sizes were selected to provide the maximum utility of the kettles in food preparation. The steamer has two compartments with a capacity of four bushels. One deep-fat fryer with a capacity of 25 pounds of fat has been provided, and for broiling purposes one range has been equipped with a broiler below. A 60-quart mixer equipped with a 30-quart bowl and meat and food chopper attachments has been placed in the cooking area. If the attachments on the mixer are too high to be convenient for the worker, then a separate meat chopper and food cutter would have to be considered. For additional oven space, one range with oven space below has been planned. This space will be utilized for preparation of holiday menus when there is a great demand for oven space.

Because of the smaller quantity of food to be prepared and less variety within the menus to be served, the equipment needed in the cooking area of the 50-bed plan is quite simple. In this plan we have placed a two-section roasting oven, smaller than that in the 100- and 200-bed plans, each section equipped with an additional shelf for baking. Other pieces of equipment in the 50-bed plan are a junior size steamer with a capacity of one bushel, one steam jacketed kettle with 10-gallon capacity, and a bench type mixer with a capacity of 20 quarts. The mixer is equipped with a 12-quart bowl and meat and food chopper attachments. One range with an oven below and one range with a fry top section and with a broiler below have been provided.

In all the kitchens, the floor area below the kettles is depressed slightly and is pitched to a floor drain. To keep the kitchen comfortable and free from unpleasant odors, an exhaust system in a properly constructed hood is placed over the cooking area.

C. *Special diets:* A special diet kitchen has not been provided in any of these plans. All special diet foods are to be prepared in units where the regular food is prepared and served to the patients in the same manner as the regular diet. The number of diets other than the normal, soft and liquid will not exceed 15 per cent of the total amount of meals served to patients. Most of the food for special diets that cannot be prepared in other units will be liquid nourishments to be served between meals and a few special weighed foods. A counter has been provided for preparing these liquid nourishments and the weighing of foods on dietetic gram scales. The liquid nourishments are transported on the food conveyors to the floor pantry at each meal time.

SERVING AND TRAY SETUP

The serving area consists of tray setup counter, the cook's table, ice cream storage, and coffee preparation unit. The focal point is the cook's table. Ample floor space is allowed for food conveyors to be filled in this area.

Space for setting up trays has been planned on a counter adjoining the clean dish table. Trays can be set up here with silver, some china, glassware, and accessory items. Cabinet space is provided for storage of these items when not in use.

Common practice is to purchase ice cream packaged in individual block form rather bulk form. If the hospital uses bulk ice cream, a running water dip well should be installed at the ice cream storage cabinet.

Adequate space for ice cream storage and preparation of coffee for patients only is provided in the kitchen of the 100- and 200-bed hospital. Ice cream storage and coffee preparation facilities for personnel are provided in the cafeteria.

In the 50-bed hospital, it is necessary to provide space in the main kitchen for ice cream storage and preparation of coffee for both patients and personnel. In the hospital of 50-bed capacity, some may prefer the five- to six-element vacuum coffee maker. This type of coffee maker would be adequate for the kitchen in place of the urn.

Food conveyors and tray trucks have been parked out of the main traffic of the kitchen but convenient to the serving area. An effort has been made to have the food conveyors parked in such a way as to provide an aisle for access in loading on one side at all times.

POT WASHING

The pot washing area is off the main traffic lines near the cooking unit (from which most of its work comes) and near the storage area for food conveyors. This location makes it easy for the pots from the

food conveyors to be cleaned and returned to the food conveyor.

For pot washing, a three-compartment sink with two drainboards has been placed in all three plans. In the 100- and 200-bed plans a food waste grinder has been installed to take care of waste from pans and food conveyors. It was omitted in the 50-bed plan because of the small amount of food waste that would be accumulated in this area. One compartment of each sink has been equipped with a dial thermometer to insure adequate sanitization of the utensils. An open pot cabinet with adjustable shelves and mounted on casters has been placed in this unit for the storage of clean pots.

DISH WASHING

In all three plans the dish washing room is situated at the entrance to the kitchen adjoining the tray setup counter and on an exterior wall for natural ventilation. This unit has been arranged so that it is convenient to the elevator leading to patients' area, convenient to the personnel dining area, and to the patient tray setup counter. All precautions have been taken to prevent the handling of soiled dishes and clean dishes by the same person. This plan requires that an employee be stationed at the clean dish table in the kitchen to handle clean dishes.

The dish washing room is the noisiest unit in the dietary department and has been closed off. It is desirable that this unit be finished so that floors and walls can be easily washed. They should be moisture-proof and the ceiling should be acoustically treated. A hood to carry away the excess vapor is provided over the dish washing machine.

It is planned that two employees will operate the dish washing unit in the 200-bed hospital, one racking dishes for the dish washing machine and one for the glass washing. The dish washing machine is a fully automatic, single tank, with approximate capacity of 4,500 pieces per hour. The load of glasses from the 200-bed hospital seemed sufficiently great to warrant the purchase of a glass washing machine.

The 100- and 50-bed plans anticipate that only one employee will be in the dish washing room. All china, glassware and silverware will be washed in automatically timed machines. The dish washing machine provided for the 100-bed plan is a single tank floor model with vertical sliding doors and an approximate capacity of 3,000 pieces per hour. The same type of machine is used in the 50-bed plan with a capacity of 1,250 pieces per hour. All three machines will accommodate a 14 x 18-inch tray.

The pre-flushing unit in this layout consists of a spray nozzle that has been installed over the food waste grinder. A double compartment sink is provided for soaking.

A hot and cold water outlet is placed in the dish-washing room for truck washing and a hand washing facility is available in the unit for the employees.

OFFICE

In the 200-bed hospital office, space has been provided for two dietitians, and in the 100-bed hospital space for one. Desk space has been provided in the 50-bed plan for the food supervisor. All three plans have been drawn up to enable nurses, doctors and salesmen to go to the dietitian's office without going through the main kitchen. For convenience, a telephone extension from this office has been placed in the kitchen area of the 200- and 100-bed hospitals.

EMPLOYEE FACILITIES

A water cooler has been placed within the kitchen area for the employees. Not shown on the plan, but close to the kitchen area, are lavatory and toilet facilities for dietary employees. Adequate hand washing facilities are in the food preparation and dish washing areas.

CAFETERIA

No kitchen plans would be complete without some provision for the cafeteria or dining room. The group served in these areas represents a much greater number than the patients. Moreover, equipping a cafeteria entails a larger expenditure.

Service to personnel in hospitals of more than 50-bed capacity is usually cafeteria style. It has been found practical and workable to use only one serving line for all.

In this plan (figure 4) we have provided the minimum amount of equipment to serve the staff of a 100-bed hospital. No provision has been made for a cashier's station. In this size facility, employees' payments for their meals probably would be on the basis of a fixed amount per meal rather than by item. In this case meal tickets might be used or a flat charge made for the meals eaten.

The cafeteria is close to the kitchen so that the food can be transported as short a distance as possible. The food would probably be replenished once or twice during the serving period. The cafeteria is placed close to the dish washing room for convenience in transporting dirty dishes.

Within the serving unit, space has been provided for the storage of dishes, glassware and serving utensils. Refrigerator space has been provided for storage of salads, desserts, milk, butter and other items to be served on the cold counter. An ice cream storage cabinet and coffee preparation unit has been placed in this area also.

The serving counter space has been set up to accommodate a menu pattern that would be the same as the patients' with these exceptions: (1) Choice of coffee, tea or milk; (2) choice of cereal, hot or cold; (3) eggs prepared in several ways; (4) facilities for preparing griddle cakes or French toast; (5) choice of two meats; (6) choice of two vegetables; (7) choice of salad, and (8) one dessert.

The cafeteria would be staffed by dietary department personnel and there would be approximately three employees in this area at the height of the serving period.

Two dining areas have been provided. Each table in the dining room will be large enough to seat four people. The seating capacity is approximately three-fifths of the average number of patrons expected. A telephone, call system, and clock have been provided in the large dining room.

An ice making machine has been placed adjacent to the dietitian's office across the hall from the cafe-

teria. A machine that could furnish both cube and crushed ice would be most adaptable. Cubes would be used in iced beverages and crushed ice in the cold pan. It may be that a refrigerated unit would be preferred to crushed ice in the cold pan. This would depend upon individual preference.

SUMMARY

The smooth flow of foodstuffs from receiving platform to preparation unit to patient and personnel is dependent upon the proper functional layout as well as the proper sized equipment. Successful planning requires the cooperation of people trained in a variety of professions.

Basically the same types of operation must be planned for in all kitchens, regardless of size. To determine the correct type, amount and size of equipment to be used in the units of the three plans, a study was made of the menus as well as the quantity of representative foods that were to be prepared in each kitchen. In this study consideration was given to the standard size pans that would be used interchangeably and the time that would be required in preparation. For example, to determine the amount of oven space that would be needed for both roasting and baking, the representative foods used were roast beef, pork loin, meat loaf, roast turkey, parker house rolls, chocolate cake, cherry pie, oatmeal cookies and muffins.

Certainly no planning is complete without an evaluation of the service that results. In the case of the dietary department the proof of the pudding is certainly in the eating, and regardless of how efficiently the food service is planned the final responsibility rests with management to use its facilities to maximum advantage to provide appetizing and nourishing food to both patients and personnel.

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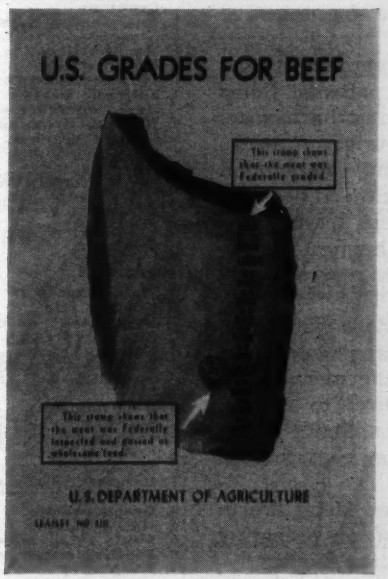
DIETETICS ADMINISTRATION COMMENT

Selecting meats

THE U. S. DEPARTMENT of Agriculture has published a leaflet designed to show how the selection of meat can be made easier for the consumer-buyer—from the inexperienced homemaker to such large quantity meat users as hospitals.



The leaflet summarizes facts about the United States grades for carcass beef and points out how they can be used as an aid in more efficient purchasing.

A specially prepared illustration shows purchasers the location of various beef cuts on a dressed carcass.

There are five main federal grades of beef—prime, choice, good, commercial, and utility. The leaflet explains these grades and tells their possible uses. A suggested cooking guide tells the best ways that each cut of each grade of beef can be prepared.

Copies of this publication, Leaflet No. 310, "U. S. Grades for Beef," are available at 10 cents each from the superintendent of documents, U. S. Government Printing Office, Washington, D. C.

Citrus juice in dieting

A New York City study has shown that the use of citrus juice 30 to 60 minutes before meals as an appetite appeaser seems to be very

effective in bringing about adherence to a prescribed dietary regimen for weight reduction.

The study was conducted by Dr. Norman Jolliffe and Dr. Elmer Alpert of the Bureau of Nutrition, New York City Department of Health.

For four consecutive weeks 42 unselected subjects, averaging 41.3 pounds overweight, were kept under observation. They were instructed to use four ounces of orange juice or grapefruit juice as an anorexic agent 30 to 60 minutes before their noon meal and again before the evening meal. Besides the citrus juice allowance, counted as 100 calories daily, each subject had prescribed for him a low calorie, high protein diet, ranging between 1,000 and 1,400 calories. At the end of the four-week study, the 42 subjects had lost a total of 603 pounds.

The Dietetics Administration department is edited by Margaret Gillam, dietetics specialist.

Plenty of cranberries

November brings Thanksgiving, and Thanksgiving suggests cranberries. The Production and Marketing Administration of the U. S. Department of Agriculture reports that cranberries are plentiful this year. The American Cranberry Exchange, a producers' sales organization, is, in fact, conducting a large-scale promotion campaign this month to push cranberry sales.

This year's crop is the third largest in history, and this fact should contribute to keeping prices reasonable.

Other plentiful foods: The agriculture department also reports that there are plenty of apples this year, and turkeys also are in plentiful supply, as are processed citrus products, raisins, cabbage, pork and canned tuna.—M. G.

Master Menus for December

The December series of the American Hospital Association's Master Menu is printed on the following pages. A general and seven special diets are provided in the menu plan.

These menus reduce to a minimum the number of diets, simplify planning, decrease costs and conserve food preparation time. The general diet forms the basis of the seven most commonly used special hospital diets. Selections to be served on the general diet are set in boldface type in the Master Menus.

Special diets in the menu plan are the soft, full liquid, high protein, high calorie, low calorie, low fat and measured or weighed. All except the full liquid diet have been planned to include the nine food essentials and servings required for nutritional adequacy. The menus are adaptable for selective service.

Consideration is also given flavor, variety, attractiveness and general acceptance by patients. Color is a factor, and color combinations must harmonize. Foods in each meal are planned in a variety of forms, not all flat, high, or round but a pleasing combination of shapes. Consistency, too, is important, and here the accent is on variety. If some foods are served in a soft form, a crisp food is included in the meal. Flavor gives zest to a meal, and this aspect receives consideration in the planning.

Master Menu kits containing the revised wall cards, sample transfer slips and the "Master Menu Diet Manual" are available to users of the menus. The kits are priced at $2 and may be secured by writing the Editorial Department of HOSPITALS. Single copies of the "Master Menu Diet Manual" may be purchased for $1.50.

Full directions for using the Master Menu are in the manual together with information on preparing 15 other special diets with the aid of the menus.

December 1

1. **Orange juice**
2. Orange juice
3. **Farina or crisp rice cereal**
4. **Soft cooked egg**
5. Bacon
6. **Toast**

7. **Consomme**
8. **Crisp crackers**
9. **Spiced rolled shoulder of lamb**
10. Roast lamb
11. **Scalloped potatoes**
12. Riced potatoes
13. **Broccoli**
14. Mashed squash
15. **Carrot and raisin salad**
16. **Mayonnaise**
17. **Pineapple upside-down sponge cake, whipped cream**
18. Sponge cake, whipped cream
19. Strawberry gelatin
20. Grapefruit sections
21. Grapefruit juice

22. **Cream of spinach soup**
23. **Croutons**
24. **Veal souffle, parsley cream sauce**
25. Veal patties
26. Veal patties
27. Parsley potatoes
28. **Julienne beets**
29. **Raw vegetable salad bowl**
30. **Russian dressing**
31. **Canned peaches**
32. Canned peaches
33. Soft custard
34. Unsweetened canned peaches
35. Apple juice
36. **Cloverleaf rolls**

December 2

1. **Half grapefruit**
2. Tomato juice
3. **Corn flakes or oatmeal**
4. **Scrambled egg**
5. Canadian bacon
6. **Cinnamon breakfast muffins**

7. **Beef bouillon**
8. **Saltines**
9. **Creamed turkey and mushrooms on hot biscuits**
10. Hot sliced turkey
11. **Paprika potatoes**
12. Boiled rice
13. **Green beans**
14. Green beans
15. **Fruit salad mold**
16. **Pineapple mayonnaise**
17. **Raspberry sherbet**
18. Raspberry sherbet
19. Cranberry ice
20. Orange and grape cup
21. Blended fruit juice

22. **Corn chowder supreme**
23. **Crisp crackers**
24. **Tomato aspic ring with cabbage carrot salad—grilled cheese sandwiches**
25. Individual lamb casserole with mashed potato topping—carrots
26. Cold sliced lamb—carrots
27. Cubed potatoes (omit on Soft Diet)
28. ———
29. **Celery sticks**
30. ———
31. **Blueberry cobbler**
32. Canned fruit cup
33. Floating island
34. Unsweetened canned fruit cocktail
35. Mixed fruit juice
36. ———

December 3

1. **Banana**
2. Apricot nectar with lemon juice
3. **Brown granular wheat cereal or puffed rice**
4. **Poached egg**
5. Bacon
6. **Toast**

7. **Julienne vegetable soup**
8. **Crisp crackers**
9. **Country fried steak**
10. Roast beef
11. **Creamed quartered potatoes**
12. Parsley potatoes
13. **Mashed rutabagas**
14. Asparagus tips
15. **Stuffed date and apricot salad**
16. **French dressing**
17. **Bread pudding**
18. Bread pudding
19. Cherry sponge
20. Unsweetened canned apricots
21. Limeade

22. **Turkey rice soup**
23. **Melba toast**
24. **Scalloped tuna fish with noodles**
25. Scalloped tuna fish with noodles
26. Low fat tuna
27. Baked noodles in broth (omit on Soft Diet)
28. **Green peas**
29. **Sliced orange salad**
30. **Pimiento French dressing**

What does it cost to SERVE TURKEY in the hospital?

Turkey is an economical meat to serve. Repeated tests have proved this . . . sometimes to the surprise of those who have carried over from the days when turkey was a once-or-twice-a-year festive bird, the mistaken notion that turkey is still a luxury meat.

One set of significant tests which was made in recent months by a highly competent expert of national reputation (name withheld on request) showed that four standard dishes when made with turkey were far more economical than when made with other poultry *at the same price per pound.* Reason for this was the higher yield (48%) of cooked edible meat obtainable from each pound of uncooked whole turkey (eviscerated weight).

COSTS OF 4 STANDARD TURKEY DISHES

Raw Cost Per Lb. Table Dressed (Eviscerated)	Cost Per Cooked Lb. 48% Yield (Turkey)	Cost 8 Lbs. Cooked (USDA Standard for Type A Lunch) (Turkey)	Cost Per 100 Servings (6 Oz.) 5 Gal. A La King (Turkey)	Cost Per 100 Servings (6 Oz.) 5 Gal. Noodle Casserole (Turkey)	Cost Per 100 Servings (1.2 Oz.) 1 Gal. Sandwich Filling (Turkey)	Cost Per 100 Servings (3.2 Oz.) 3—3¼ Gal. Salad (Turkey)
$ .42	$ .875	$6.80	$8.74	$7.99	$4.11	$10.06
.45	.94	7.52	9.46	8.71	4.47	10.78
.48	1.00	8.00	9.94	9.19	4.71	11.26
.51	1.06	8.47	10.42	9.67	4.95	11.74
.53	1.10	8.80	10.74	9.99	5.11	12.06
.55	1.15	9.20	11.14	10.39	5.31	12.46

For complete details of these tests and copy of a reprint, "When Turkey Appears on the Menu, It Makes Good Meals at Reasonable Cost," send the coupon.

NATIONAL TURKEY FEDERATION
Mt. Morris, Illinois

- ☐ Please send me FREE booklet "A Dish A Day" complete with 30 profit-making turkey recipes.
- ☐ Also a reprint of "When Turkey Appears on the Menu, It Makes Good Meals at Reasonable Cost."

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NATIONAL TURKEY FEDERATION

MT. MORRIS - ILLINOIS

31. **Prune cake with lemon frosting**
32. Pear half in strawberry gelatin
33. Strawberry gelatin, custard sauce
34. Fresh pear
35. Cranberry juice
36. **Cranberry muffins**

December 4

1. **Fresh grapes**
2. Pineapple juice
3. **Puffed wheat or hominy grits**
4. **Soft cooked egg**
5. Link sausages
6. **Toast**

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7. **Grapefruit juice**
8. ———
9. **Veal fricassee on rice**
10. Baked veal chop
11. ———
12. Whipped potatoes
13. **Brussels sprouts**
14. Carrot rings
15. **Molded cranberry salad**
16. **Mayonnaise**
17. **Boston cream pie**
18. Boston cream pie
19. Whipped lime gelatin
20. Unsweetened canned bing cherries
21. Beef bouillon

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22. **Cream of tomato soup**
23. **Croutons**
24. **Broiled Canadian bacon—corn fritters with syrup**
25. Scrambled eggs—crisp bacon
26. Hot beef cubes
27. Baked potato
28. **Whole green beans**
29. **Tossed vegetable salad**
30. **Blue cheese dressing**
31. **Baked apple**
32. Applesauce
33. Cream pudding
34. Grapefruit sections
35. Orange juice
36. **Bread**

December 5

1. **Tangerine**
2. Grapefruit juice
3. **Farina or shredded wheat**
4. **Poached egg**
5. Bacon
6. **Bran muffins**

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7. **Beef broth**
8. **Saltines**
9. **Roast lamb**
10. Roast lamb
11. **Parsley potatoes**
12. Parsley potatoes
13. **Creole corn**
14. Spinach
15. **Pear, raisin and grated cheese salad**
16. **French dressing**
17. **Chocolate chip ice cream**
18. Chocolate chip ice cream
19. Lemon ice
20. Fresh pear
21. Blended fruit juice

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22. **Cream of celery soup**
23. **Crisp crackers**
24. **Hamburger with chopped olives on toasted bun—potato chips**
25. Broiled beef patties
26. Broiled beef patties
27. Cubed potatoes
28. **Asparagus tips**
29. **Tomato salad**
30. **Mayonnaise**
31. **Banana cream pie**
32. Sliced banana in orange juice
33. Baked custard
34. Orange and banana cup
35. Pineapple juice
36. ———

December 6

1. **Tomato juice**
2. Tomato juice
3. **Corn flakes or oatmeal**
4. **Scrambled egg**
5. Bacon
6. **Toast**

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7. **Cream of pea soup**
8. **Croutons**
9. **Smoked tongue with raisin sauce**
10. Cubed steak
11. **Mashed potatoes**
12. Riced potatoes
13. **Kale with lemon**
14. Baked squash
15. **Waldorf salad**
16. ———
17. **Norwegian prune pudding, whipped cream**
18. Prune whip, whipped cream
19. Raspberry and lemon gelatin cubes
20. Unsweetened canned boysenberries
21. Orange juice

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22. **Vegetable soup**
23. **Saltines**
24. **Hot roast pork sandwich with gravy**
25. Baked liver
26. Baked liver
27. Paprika potatoes
28. **Sliced carrots**
29. **Head lettuce salad**
30. **Chiffonade dressing**
31. **Peppermint stick ice cream**
32. Royal Anne cherries
33. Peppermint stick ice cream
34. Fresh pineapple
35. Grapefruit juice
36. ———

December 7

1. **Orange juice**
2. Orange juice
3. **Rolled wheat or crisp rice cereal**
4. **Soft cooked egg**
5. Grilled ham
6. **Coffee cake**

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7. **Tomato rice soup**
8. **Crisp crackers**
9. **Baked breaded haddock fillets—tartar sauce**
10. Baked haddock fillets—lemon wedge
11. **Au gratin potatoes**
12. Cubed potatoes
13. **Sliced beets**
14. Sliced beets
15. **Cream cole slaw**
16. ———
17. **Apple dumpling**
18. Vanilla blanc mange
19. Lime ice
20. Fresh grapes
21. Grapefruit juice

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22. **Cream of mushroom soup**
23. **Toast sticks**
24. **Salmon pattie with parsley cream sauce**
25. Creamed salmon
26. Cottage cheese
27. Baked potato
28. **Green peas**
29. **Asparagus salad with pimiento strip garnish**
30. **French dressing**
31. **Pineapple, apricot and plum compote**
32. Canned peeled apricots
33. Vanilla blanc mange
34. Unsweetened canned apricots
35. Grapeade
36. **Oatmeal rolls**

December 8

1. **Half grapefruit**
2. Blended citrus juice
3. **Puffed rice or brown granular wheat cereal**
4. Poached egg (omit on Normal Diet)
5. Bacon
6. **French toast—currant jelly**

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7. **Beef noodle soup**
8. **Saltines**
9. **Meat loaf with gravy**
10. Broiled beef patties
11. **O'Brien potatoes**
12. Whipped potatoes
13. **Green beans**
14. Green beans
15. **Layered tomato, cottage cheese and chive salad**
16. **Mayonnaise**
17. **Peach shortcake**
18. Peach floating island
19. Grape sponge
20. Unsweetened canned peaches
21. Lemonade

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22. **Split pea and celery soup**
23. **Crisp crackers**
24. **Scrambled eggs and noodles—grilled chicken livers**
25. Scrambled eggs—chicken livers
26. Baked veal chop
27. Noodles
28. **Spinach**
29. **Fresh pear and grape salad**
30. **French dressing**
31. **Jelly roll**
32. Jelly roll
33. Floating island
34. Unsweetened canned boysenberries
35. Peach and lemon nectar
36. **French bread**

December 9

1. **Orange halves**
2. Orange juice
3. **Farina or wheat and barley kernels**
4. **Soft cooked egg**
5. Link sausages
6. **Toast**

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7. **Cranberry juice**
8. ———
9. **Oven-fried chicken**
10. Roast chicken
11. **Baked mashed sweet-potatoes with marshmallow topping**
12. Riced potatoes
13. **Buttered cauliflower**
14. Green peas
15. **Apricot, banana and cherry salad**
16. **Fruit salad dressing**
17. **Vanilla ice cream**
18. Vanilla ice cream
19. Lemon ice
20. Grapefruit sections
21. Consomme

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22. **Cream of spinach soup**
23. **Saltines**
24. **Grilled tomato on toast, rarebit sauce**
25. Welsh rarebit on toast
26. Broiled lamb chop
27. Stuffed baked potato
28. **Asparagus tips**
29. **Shredded cabbage, carrot and green pepper salad**
30. **Tarragon dressing**
31. **Royal Anne cherries—chocolate cookies**
32. Royal Anne cherries
33. Chocolate rennet-custard
34. Unsweetened canned Royal Anne cherries
35. Pineapple juice
36. **Bread**

December 10

1. **Tomato juice**
2. Tomato juice
3. **Shredded wheat or hominy grits**
4. **Scrambled egg**
5. Bacon
6. **Whole wheat muffins**

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7. **Chicken noodle soup**
8. **Melba toast**
9. **Stuffed breast of veal—currant jelly**
10. Baked plain veal patties
11. **Browned potatoes**
12. Whipped potatoes
13. **Mashed Hubbard squash**
14. Mashed Hubbard squash
15. **Escarole, grape and sliced kumquat salad**
16. **French dressing**
17. **Baked coconut custard**
18. Baked custard with jelly
19. Whipped strawberry gelatin
20. Unsweetened canned prune plums
21. Orange juice

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22. **Cream of vegetable soup**
23. **Crisp crackers**
24. **Chopped beef and mushroom saute on toast**
25. Chopped beef on toast
26. Broiled steak
27. Parsley potato balls
28. **Quartered carrots**
29. **Tossed salad**
30. **Celery seed French dressing**
31. **Baked apple, glazed—soft molasses cookies**
32. Applesauce
33. Baked custard
34. Unsweetened canned blackberries
35. Apricot nectar
36. **Bread**

December 11

1. **Half grapefruit**
2. Grapefruit juice
3. **Oatmeal or puffed rice**
4. **Poached egg**
5. Bacon
6. **Toast**

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7. **Julienne vegetable soup**
8. **Saltines**
9. **Glazed ham loaf**
10. Roast lamb
11. **Scalloped potatoes**
12. Riced potatoes
13. **Green peas**
14. Green peas
15. **Pineapple ring filled with cranberry orange relish**
16. ———
17. **Date torte, whipped cream**
18. Lemon snow pudding, custard sauce
19. Lemon snow pudding
20. Fresh pineapple wedges
21. Limeade

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22. **Corn chowder**
23. **Melba toast**
24. **Baked liver—duchess potatoes**
25. Baked liver
26. Baked liver
27. Baked potato
28. **French style beans**
29. **Lettuce wedge with tomato slices**
30. **Savory French dressing**
31. **Fruit cocktail**
32. Canned fruit cup
33. Raspberry gelatin, custard sauce
34. Unsweetened canned fruit cocktail
35. Blended fruit juice
36. **Blueberry muffins**

December 12

1. **Banana**
2. Blended fruit juice
3. **Corn flakes or brown granular wheat cereal**
4. **Soft cooked egg**
5. Grilled ham
6. **Toast**

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7. **French onion soup**
8. **Rye bread croutons**
9. **Roast beef**
10. Roast beef
11. **Mashed potatoes**
12. Potato balls
13. **Baked eggplant**
14. Sliced beets
15. **Shredded lettuce salad**
16. **Thousand Island dressing**
17. **Dried apricot pie a la mode**
18. Vanilla ice cream with sliced peach sauce
19. Lime ice
20. Unsweetened canned peaches
21. Grapefruit juice

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22. **Cream of tomato soup**
23. **Saltines**
24. **Spaghetti and cheese loaf, mushroom sauce**
25. Spaghetti and cheese
26. Baked veal steak
27. Spaghetti baked in broth (omit on Soft Diet)
28. **Chopped spinach with egg garnish**
29. **Sliced orange and grapefruit salad**
30. **French dressing**
31. **Raisin spice cake, seafoam frosting**
32. Prune whip
33. Baked custard
34. Fresh grapes
35. Pineapple juice
36. **Hard rolls**

December 13

1. **Orange juice**
2. Orange juice
3. **Farina or wheat flakes**
4. **Poached egg**
5. Bacon
6. **Honey raisin buns**

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7. **Consomme**
8. **Whole wheat wafers**
9. **Old-fashioned chicken pie—cranberry sauce**
10. Hot sliced chicken
11. **Potato cubes** (in chicken pie)
12. Whipped potatoes
13. **Brussels sprouts**
14. Sliced carrots
15. **Peach cup salad with green pepper ring**
16. **Fruit salad dressing**

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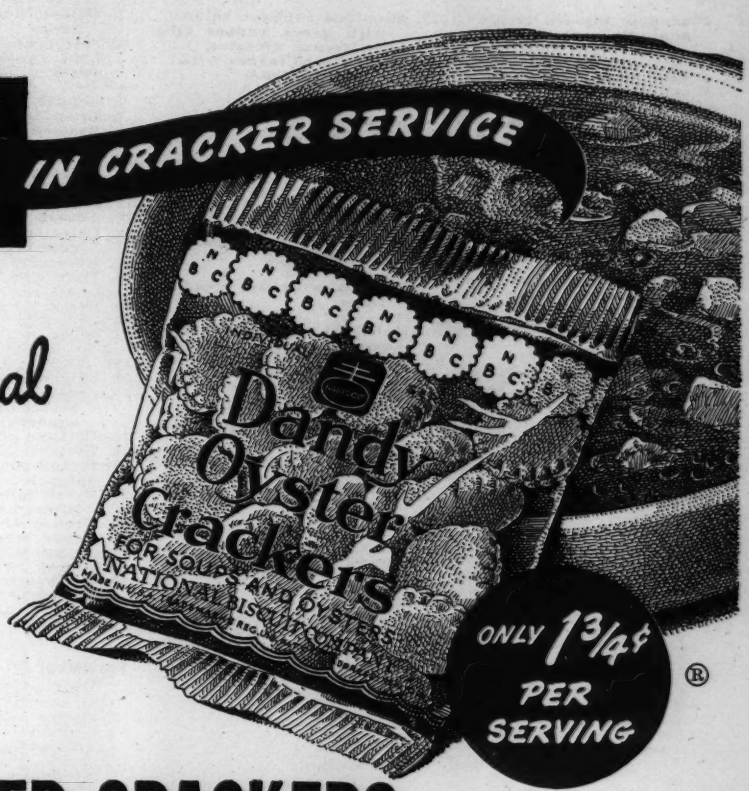

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The new cellophane package retains the oven-baked crispness which makes Dandy Oyster Crackers so tempting and delicious.

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17. **Pineapple tapioca cream pudding with meringue**
18. Tapioca cream pudding
19. Cherry sponge
20. Fresh pear
21. Blended citrus juice

22. **Cream of chicken soup**
23. **Crisp crackers**
24. **Stuffed pepper with rice and meat, tomato sauce—potato sticks**
25. Baked rice and meat with tomato puree sauce
26. Cold roast beef
27. **Baked sweetpotato** (omit on Soft Diet)
28. **Green peas**
29. **Raw vegetable salad bowl**
30. **Blue cheese dressing**
31. **Chocolate eclair**
32. Canned peeled whole apricots
33. Strawberry gelatin
34. Unsweetened canned boysenberries
35. Peach nectar
36. **Bread**

December 14

1. **Seedless grapes**
2. Grapefruit juice
3. **Crisp rice cereal or rolled wheat**
4. **Scrambled egg**
5. Link sausages
6. **Toast**

7. **Essence of celery soup**
8. **Crisp crackers**
9. **Baked salmon steak, lemon butter sauce**
10. Baked salmon steak
11. **Steamed potatoes, parsley cream sauce**
12. Steamed potatoes
13. **Whole kernel corn**
14. Asparagus
15. **Head lettuce salad**
16. **Cucumber mayonnaise**
17. **Cherry delight cake, foamy sauce**
18. Pineapple whip
19. Pineapple whip
20. Diced orange cup
21. Orange juice

22. **Old-fashioned potato soup**
23. **Saltines**
24. **Cheese souffle—currant jelly**
25. Cheese souffle—currant jelly
26. Low fat tuna on lettuce
27. Baked potato
28. **French style green beans**
29. **Tomato and watercress salad**
30. **Mayonnaise**
31. **Honey baked pear**
32. Canned pear
33. Raspberry rennet-custard
34. Fresh pineapple
35. Apple juice
36. **Parker House rolls**

December 15

1. **Half grapefruit**
2. Tomato juice
3. **Brown granular wheat cereal or puffed rice**
4. **Soft cooked egg**
5. Canadian bacon
6. **Toast**

7. **Cream of corn soup**
8. **Melba toast**
9. **Beef stew with vegetables**
10. Roast lamb
11. **Potato cubes** (in beef stew)
12. **Riced potatoes**
13. **Baked Hubbard squash with butter and brown sugar**
14. Mashed Hubbard squash
15. **Stuffed prune salad with cherry garnish**
16. **Cream mayonnaise**
17. **Apple cobbler, brown sugar nutmeg sauce**
18. Baked rice custard
19. Grape juice gelatin
20. Unsweetened canned fruit cocktail
21. Limeade

22. **Chilled tomato juice**
23. ——
24. **Sausage pattie—candied yams—pineapple ring**
25. Broiled beef patties
26. Broiled beef patties
27. Baked yam
28. **Spinach with lemon**
29. **Shredded cabbage salad with green pepper ring**
30. **Sour cream dressing**
31. **Gingerbread layers with whipped cream**
32. Applesauce
33. Baked custard
34. Unsweetened canned cherries
35. Beef bouillon
36. **Bread**

December 16

1. **Banana**
2. Pineapple juice
3. **Corn flakes or oatmeal**
4. **Scrambled egg**
5. Bacon
6. **Cinnamon raisin bread toast**

7. **Julienne vegetable soup**
8. **Crisp crackers**
9. **Roast chicken with dressing, gravy**
10. Roast chicken
11. **Mashed potatoes**
12. Whipped potatoes
13. **Green Lima beans**
14. Julienne carrots
15. **Cinnamon apple salad on endive**
16. **Whipped cream dressing**
17. **Lime sherbet**
18. Lime sherbet
19. Lime ice
20. Fresh grapes
21. Orange juice

22. **Cream of celery soup**
23. **Saltines**
24. **Cold plate—sliced luncheon loaf, deviled egg, potato salad**
25. Casserole of minced lamb with mashed potato topping
26. Cold sliced lamb—sliced beet salad
27. Parsley potato balls (omit on Soft Diet)
28. **Asparagus**
29. ——
30. ——
31. **Fresh fruit cup—chocolate chip cookies**
32. Grapefruit sections
33. Vanilla blanc mange
34. Grapefruit sections
35. Grapeade
36. **Rye bread**

December 17

1. **Orange juice**
2. Orange juice
3. **Farina or wheat and barley kernels**
4. **Poached egg**
5. Bacon
6. **Toast**

7. **Consomme**
8. **Saltines**
9. **Roast loin of pork—spiced applesauce**
10. Baked veal chop
11. **Oven browned potatoes**
12. Cubed potatoes
13. **Diced rutabagas**
14. Green beans
15. **Banana, peach and cherry salad**
16. **Fruit salad dressing**
17. **Chocolate cake squares with chocolate nut frosting**
18. Chocolate cake squares
19. Whipped cherry gelatin
20. Unsweetened canned blackberries
21. Grapefruit juice

22. **Cream of mushroom soup**
23. **Crisp crackers**
24. **Salisbury steak—stuffed baked potato with parsley and onion**
25. Broiled beef patties
26. Broiled beef patties
27. Noodles baked in broth
28. **Green peas**
29. **Sliced Chinese cabbage salad**
30. **Thousand Island dressing**
31. **Tangerine and grapes**
32. Canned peaches
33. Floating island
34. Tangerine sections
35. Pineapple juice
36. **Soft rolls**

December 18

1. **Tomato juice**
2. **Tomato juice**
3. **Wheat flakes or hominy grits**
4. **Soft cooked egg**
5. Link sausages
6. **Toast**

7. **Pepper pot soup**
8. **Crisp crackers**
9. **Braised liver**
10. Baked liver
11. **Pimiento potato souffle**
12. Riced potatoes
13. **Cauliflower au gratin**
14. Sliced carrots
15. **Tossed salad**
16. **Celery seed French dressing**
17. **Blueberry pie**
18. Pear half in strawberry gelatin
19. Grape sponge
20. Grapefruit sections
21. Limeade

22. **Chicken rice broth**
23. **Saltines**
24. **Creamed ham and mushrooms on cornbread squares**
25. Cottage cheese
26. Cottage cheese
27. Baked potato
28. **Spinach with lemon**
29. **Fresh pineapple and orange salad**
30. **French dressing**
31. **Prune whip**
32. Prune whip
33. Baked custard
34. Unsweetened canned prune plums
35. Apricot nectar
36. **Bread**

December 19

1. **Half grapefruit**
2. Grapefruit juice
3. **Rolled wheat or crisp rice cereal**
4. **Scrambled egg**
5. Bacon
6. **Cinnamon buns**

7. **Cream of pea soup**
8. **Melba toast**
9. **Roast veal or baked cod fillets**
10. Roast veal
11. **Mashed potatoes**
12. Whipped potatoes
13. **Harvard beets**
14. Sliced beets
15. **Perfection salad**
16. **Mayonnaise**
17. **Maple walnut ice cream**
18. Vanilla ice cream
19. Lemon ice
20. Unsweetened canned fruit cocktail
21. Blended citrus juice

22. **Tomato rice soup**
23. **Crisp crackers**
24. **Scalloped oysters**
25. Creamed eggs
26. Poached salmon, lemon wedge
27. Parsley potatoes
28. **Green beans**
29. **Celery hearts and radishes**
30. ——
31. **Orange and banana shortcake**
32. Sliced bananas in orange juice
33. Soft custard
34. Sliced orange
35. Apple juice
36. **Bread**

December 20

1. **Tangerine**
2. Orange juice
3. **Puffed rice or oatmeal**
4. **Soft cooked egg**
5. Grilled ham
6. **Toast**

7. **Beef bouillon**
8. **Saltines**
9. **Swiss steak**
10. Broiled steak
11. **Browned rice**
12. Baked potato
13. **Mashed Hubbard squash**
14. Mashed Hubbard squash
15. **Sliced head lettuce salad**
16. **Blue cheese dressing**
17. **Lemon snow pudding, custard sauce**
18. Lemon snow pudding, custard sauce
19. Lemon snow pudding
20. Unsweetened canned bing cherries
21. Grapefruit juice

22. **Cream of spinach soup**
23. **Croutons**
24. **Open faced lettuce, tomato and bacon sandwich**
25. Cold sliced chicken—quartered carrots
26. Cold sliced chicken—quartered carrots
27. Riced potatoes
28. ——
29. **Mixed green salad**
30. **Vinegar-oil dressing**
31. **Peach and frozen raspberry compote**
32. Royal Anne cherries
33. Lemon gelatin cubes, custard sauce
34. Delicious apple
35. Cranberry and pineapple juice
36. ——

December 21

1. **Fresh pear**
2. Tomato juice
3. **Farina or raisin bran flakes**
4. **Poached egg**
5. Bacon
6. **Toast**

7. **Corn chowder**
8. **Crisp crackers**
9. **Baked mackerel fillet**
10. Baked ocean perch fillet
11. **O'Brien potatoes**
12. Boiled potatoes
13. **Scalloped tomatoes**
14. Green beans
15. **Jellied vegetable salad**
16. **Mayonnaise**
17. **Banana cream pie**
18. Banana cream pudding
19. Orange ice
20. Fresh pineapple
21. Blended citrus juice

22. **Cream of asparagus soup**
23. **Saltines**
24. **Scalloped tuna fish**
25. Creamed tuna fish
26. Low fat tuna fish on lettuce
27. Baked potatoes
28. **Green peas**
29. **Sliced orange and watercress salad**
30. **Creole dressing**
31. **Marble cake squares with chocolate frosting**
32. Canned pears
33. Cream pudding
34. Unsweetened canned blackberries
35. Grapeade
36. **Cloverleaf rolls**

December 22

1. **Emperor grapes**
2. Blended citrus juice
3. **Corn flakes or rolled wheat**
4. **Scrambled egg**
5. Bacon
6. **Corn muffins**

7. **Consomme**
8. **Saltines**
9. **Baked ham or baked breaded halibut**
10. Baked halibut steak
11. **Au gratin potatoes**
12. Whipped potatoes
13. **Whole kernel corn or spinach**
14. Spinach
15. **Cabbage and raisin slaw**
16. ——
17. **Vanilla ice cream, pineapple sauce**
18. Vanilla ice cream
19. Pineapple whip
20. Unsweetened canned pear and bing cherry compote
21. Orange juice

22. **Cream of mushroom soup**
23. **Crisp crackers**
24. **Fluffy cheese rice omelet**
25. Plain omelet—jelly
26. Plain omelet
27. ——
28. **Asparagus**
29. **Tomato salad**
30. **Mayonnaise dressing**
31. **Banana cake with white mountain icing**
32. Canned peeled whole apricots
33. **Baked custard**

Around the Wards with Kellogg's

Patient CLARK De-licious! My favorite breakfast to make me feel right at home! (Right! Kellogg's cereals are a tasty treat. Kellogg's cereals are favorites with kids and grown-ups the country over.)

Nurse DOUGHERTY I don't know what I'd do without Kellogg's Individuals. They save me time—there's a choice for everyone—and what a cinch to serve!

Dietitian BROWN Breakfast planning is so much easier with Kellogg's big assortment of flakes, shredded and popped cereals. And they're healthful too—all either are made from the whole grain or are restored to whole grain levels of thiamine, niacin and iron!

KELLOGG'S NEW INDIVIDUAL PACKAGE IS EASY TO USE *2 WAYS!*

Just take the box in both hands and break open the top along the perforated line as shown. That's all there is to it! A perfect portion every time! (And for extra fun, eat right out of the package—just open the little perforated doors on the back of the box and pour the milk right on!) Either way, Kellogg's new Individual Box is CONVENIENT FOR YOU!

KELLOGG'S CORN FLAKES • RICE KRISPIES • PEP • KELLOGG'S 40% BRAN FLAKES • CORN-SOYA
KRUMBLES • KELLOGG'S SHREDDED WHEAT • KELLOGG'S RAISIN BRAN FLAKES • ALL-BRAN

34. Unsweetened canned apricots
35. Mixed fruit juice
36. **Hot biscuits—strawberry jam**

December 23

1. **Orange juice**
2. Orange juice
3. **Brown granular wheat cereal or puffed wheat**
4. **Poached egg**
5. Canadian bacon
6. **Toast**

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7. **Beef noodle soup**
8. **Melba toast**
9. **Braised beef roast**
10. Braised beef roast
11. **Oven browned potatoes**
12. Paprika potatoes
13. **Diced white turnips and peas**
14. Green peas
15. **Frozen fruit salad or head lettuce salad**
16. ———
17. **Lemon chiffon pie**
18. Lemon chiffon pudding
19. Cranberry ice
20. Half grapefruit
21. Grapefruit juice

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22. **Cream of chicken soup**
23. **Saltines**
24. **Club sandwich plate (triple decker of minced ham, sliced cheese, crisp lettuce and mayonnaise)**
25. Cottage cheese—sliced beets
26. Cottage cheese—sliced beets
27. Stuffed baked potato
28. ———
29. **Rose radishes and celery sticks**
30. ———
31. **Baked apple—butter cookies**
32. Canned peaches
33. Lemon chiffon pudding
34. Unsweetened canned peaches
35. Apricot nectar
36. ———

December 24

1. **Tomato juice**
2. Tomato juice
3. **Crisp rice cereal or oatmeal**
4. **Soft cooked egg**
5. Link sausages
6. **Sally Lunn**

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7. **Vegetable soup**
8. **Crisp crackers**
9. **Bacon wrapped lamb patties**
10. Baked plain lamb patties
11. **Baked potato**
12. Baked potato
13. **Broccoli with lemon sauce**
14. Quartered carrots
15. **Spiced beet salad**
16. **French dressing**
17. **Cheese and crackers, jelly**
18. Cream cheese and crackers, jelly
19. Strawberry gelatin
20. Unsweetened canned boysenberries
21. Orange juice

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22. **Cream of tomato soup**
23. **Croutons**
24. **Assorted cold cuts—scalloped potatoes**
25. Minced beef—asparagus
26. Cold roast beef—peas
27. Riced potatoes
28. ———
29. **Asparagus and pimiento salad**
30. **French dressing**
31. **Minted fruit cup—Christmas wreath cookies**
32. Royal Anne cherries
33. Baked custard
34. Minted orange cup
35. Pineapple juice
36. **Rye bread**

December 25

1. **Tangerine and grapes**
2. Orange juice
3. **Farina or shredded wheat**
4. **Scrambled egg**
5. Grilled ham
6. **Toast**

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7. **Christmas Madrilene soup or grapefruit, avocado and pomegranate cocktail**
8. **Saltines**
9. **Roast turkey, savory dressing—giblet gravy—cranberry sauce**
10. Roast turkey
11. **Snowflake potatoes**
12. Snowflake potatoes
13. **Mashed squash or green beans**
14. Mashed squash or green beans
15. **Christmas salad**
16. **French dressing**
17. **Hot plum pudding with foamy sauce or vanilla ice cream with mint sauce**
18. Vanilla ice cream with mint sauce
19. Lime ice
20. Grapefruit and pomegranate seed cup
21. Tomato juice
    Favors—hard candies in Christmas nut cups

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22. **Oyster stew**
23. **Oyster crackers**
24. **Tomato poinsettia salad—chopped olive and cream cheese sandwiches**
25. Sliced turkey sandwich—green peas
26. Cold sliced turkey—tomato poinsettia salad
27. Steamed rice, parsley garnish
28. ———
29. **Celery hearts**
30. ———
31. **Pineapple—Christmas cake squares**
32. Pear with maraschino cherry in lime gelatin
33. Soft custard with whipped cream, lime gelatin garnish
34. Fresh pineapple
35. Cranberry juice
36. ———

December 26

1. **Blended citrus juice**
2. Blended citrus juice
3. **Wheat flakes or hominy grits**
4. **Poached egg**
5. Bacon
6. **Toast**

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7. **Cream of pea soup with vermicelli**
8. **Crisp crackers**
9. **Country fried liver**
10. Baked liver
11. **Quartered potatoes in cream sauce**
12. Riced potatoes
13. **Stewed tomatoes and celery**
14. Sliced beets
15. **Orange and cress salad**
16. **Sweet French dressing**
17. **Chocolate whipped cream roll**
18. Chocolate whipped cream roll
19. Whipped orange gelatin
20. Unsweetened canned peaches
21. Grapefruit juice

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22. **Turkey rice soup**
23. **Saltines**
24. **Spoonbread, link sausages—glazed apple ring**
25. Broiled lamb chop
26. Broiled lamb chop
27. Baked potato
28. **Spinach with lemon wedge**
29. **Crisp green salad**
30. **French dressing**
31. **Canned prune plums**
32. Canned peeled whole apricots
33. Chocolate Bavarian
34. Unsweetened canned prune plums
35. Pineapple juice
36. **Bread**

December 27

1. **Fresh pear**
2. Prune juice with lemon
3. **Rolled wheat or corn flakes**
4. **Scrambled egg**
5. Bacon
6. **Butterscotch pecan rolls**

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7. **French onion soup**
8. **Rye cheese croutons**
9. **Short ribs of beef**
10. Broiled steak
11. **Baked noodles**
12. Whipped potatoes
13. **Glazed carrots**
14. Sliced carrots
15. **Pear and cottage cheese salad with pepper ring**
16. **Mayonnaise**
17. **Coffee ice cream**
18. Coffee ice cream
19. Lemon ice
20. Fresh pear
21. Blended citrus juice

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22. **Cream of corn soup**
23. **Melba toast**
24. **Chicken croquettes, parsley cream sauce**
25. Creamed chicken
26. Sliced chicken
27. Parsley potatoes
28. **Green peas**
29. **Sliced tomato salad**
30. **Mayonnaise**
31. **Baked apple, glazed**
32. Sliced banana in orange juice
33. Floating island
34. Sliced banana in orange juice
35. Fruitade
36. **Bread**

December 28

1. **Half grapefruit**
2. Grapefruit juice
3. **Crisp rice cereal or brown granular wheat cereal**
4. **Soft cooked egg**
5. Link sausages
6. **Toast**

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7. **Corn and tomato chowder**
8. **Oyster crackers**
9. **Fried scallops—tartar sauce**
10. Broiled flounder fillets
11. **Mashed potatoes**
12. Cubed potatoes
13. **French style green beans**
14. French style green beans
15. **Cabbage, green pepper and pimiento slaw**
16. ———
17. **Fruit ambrosia**
18. Vanilla blanc mange, apricot puree sauce
19. Raspberry and lemon gelatin cubes
20. Orange and grape cup
21. Limeade

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22. **Cherry juice with lemon ice**
23. ———
24. **Macaroni and cheese**
25. Macaroni and cheese
26. Cottage cheese
27. Baked yam (omit on Soft Diet)
28. **Asparagus**
29. **Fresh pear and grape salad**
30. **Chantilly dressing**
31. **Devil's food cake with white mountain icing**
32. Prune whip
33. Vanilla blanc mange
34. Delicious apple
35. Essence of celery soup
36. **Hard rolls**

December 29

1. **Orange halves**
2. Apricot nectar with lemon juice
3. **Farina or wheat and barley kernels**
4. **Poached egg**
5. Bacon
6. **Plain muffins**

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7. **Beef bouillon**
8. **Saltines**
9. **Roast veal with celery dressing**
10. Roast veal
11. **Paprika potatoes**
12. Paprika potatoes
13. **Cauliflower au gratin**
14. Julienne beets
15. **Cranberry and orange relish on lettuce**
16. ———
17. **Pineapple whip, custard sauce**
18. Pineapple whip, custard sauce
19. Pineapple whip
20. Fresh pineapple
21. Blended citrus juice

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22. **Cream of celery soup**
23. **Crisp crackers**
24. **Hamburgers in barbecue sauce**
25. Broiled beef patties
26. Broiled beef patties
27. Parsley potato balls
28. **Baked acorn squash**
29. **Head lettuce salad**
30. **Roquefort cheese dressing**
31. **Peach cobbler**
32. Royal Anne cherries
33. Baked custard
34. Unsweetened canned Royal Anne cherries
35. Grapefruit juice
36. **French bread**

December 30

1. **Blended citrus juice**
2. Blended citrus juice
3. **Corn flakes or oatmeal**
4. **Scrambled egg**
5. Bacon
6. **Toast**

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7. **Pineapple juice**
8. ———
9. **Baked ham**
10. Roast beef
11. **Orange candied yams**
12. Whipped potatoes
13. **Spinach with lemon wedge**
14. Spinach with lemon wedge
15. **Carrot and raisin salad**
16. **Mayonnaise**
17. **Lemon custard ice cream**
18. Lemon custard ice cream
19. Orange ice
20. Unsweetened canned apricots
21. Consomme

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22. **Oxtail soup**
23. **Saltines**
24. **Eggs a la king on corn bread**
25. Creamed diced veal—sliced carrots
26. Cold roast veal—sliced carrots
27. Baked noodles in broth
28. ———
29. **Cauliflower, green bean and tomato quarter salad**
30. **Vinegar—oil dressing**
31. **Canned pears—date squares**
32. Canned pears
33. Lemon custard ice cream
34. Fresh pear
35. Cranberry and apple juice
36. **Bread**

December 31

1. **Fresh grapes**
2. Grapefruit juice
3. **Rolled wheat or puffed rice**
4. **Poached egg**
5. Link sausages
6. **Toast**

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7. **Chicken rice soup**
8. **Saltines**
9. **Beef and vegetable pie**
10. Roast lamb
11. **Potato cubes** (in meat pie)
12. Riced potatoes
13. **Broccoli with lemon butter**
14. Green peas
15. **Tomato aspic ring filled with cole slaw**
16. ———
17. **Orange chiffon pie**
18. Orange chiffon pudding
19. Cherry sponge
20. Unsweetened canned fruit cocktail
21. Limeade

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22. **Cream of mushroom soup**
23. **Crisp crackers**
24. **Canadian bacon and asparagus on toast with cheese sauce**
25. Welsh rarebit on toast—asparagus
26. Hot cubed beef—asparagus
27. Baked potato
28. ———
29. **Grapefruit and red apple sections salad**
30. **French dressing**
31. **Coconut cup cakes**
32. Applesauce
33. Orange chiffon pudding
34. Unsweetened canned boysenberries
35. Mixed fruit juice
36. **Bread**

Three major steps can produce a good maintenance program

LOUIS L. BREGA

DURING THE PAST several years, the term "preventive maintenance" has come more and more into common usage as maintenance engineers have become increasingly aware of its importance. Preventive maintenance basically means the process of establishing a system of periodic inspections and servicing designed to maintain facilities in good operating condition to avoid necessity of having to make major repairs with resultant greater expense.

The value of preventive maintenance cannot be exaggerated, particularly in areas such as the operating room where uninterrupted service is so essential. Very often it is difficult to arrange a schedule of periodic servicing because of the nature of activities in operating rooms. If the problem is approached with an understanding of what the hospital engineer is trying to do for the operating room supervisor, some arrangement can be worked out which will greatly reduce the frequency of emergency calls.

CONTINUOUS PROGRAM NEEDED

Every good painter knows that a coat of paint applied at certain specified intervals is comparatively easy work and indefinitely preserves the structure involved. To neglect this preventive maintenance not only might result in damage to the structure—rust or rot—but could entail a costly, difficult job, including scraping or burning of the surface, to bring back a semblance of the original soundness and appearance.

This applies equally to the other skills, for example, the carpenters oiling casters and removing lint, or the steamfitter disassembling and cleaning steam traps during the summer to assure a comparatively trouble-free winter.

An orderly pattern should be charted and duties assigned to those best fitted to carry out a continuous preventive maintenance program. A check list showing the items and specifying in detail the type of maintenance required for each item should be drawn up and referred to on routine rounds. The work should be divided into areas and regularly scheduled periods of time.

THREE-PART APPROACH

Hospital engineers will find that a very simple inspection and servicing schedule suffices to establish an effective preventive maintenance system. The various steps involved are:

1. *Make a listing of all equipment* divided into main classifications: Mechanical, electrical, steam, plumbing, carpentry and other types.

2. *Make a schedule of periodic inspections and servicing* under each heading on the basis of past experience and reliable information.

3. *Maintain a simple system of records* to insure that inspections are actually being made on schedule and to indicate the locations of the equipment and the dates on which servicing was performed.

A good start can be made on a preventive maintenance program at any time; the hospital engineer need not wait until he is ready to adopt a complete program. The initial step might be to select an area, such as the laundry, where good maintenance is particularly important. The steps suggested below could be followed.

1. Make a complete card listing of all laundry equipment, separating the mechanical from the electrical. Include all nameplate data, dates of installation, capacity, steam consumption and horsepower rating of motors.

2. Obtain from the manufacturer, if not already available, catalogs covering repair parts and servicing, outlining in detail the recommended inspection and servicing schedule.

3. Establish periodic inspection and servicing schedules on the basis of manufacturers' recommendations, using a check list form with dates. The schedules will have to be developed in coordination with the laundry manager so that he can arrange to have the work done during regular working hours.

Maintenance records may be as simple or elaborate as conditions warrant. The main thing is to establish a firm schedule of inspections and servicing with a check system. Good records will help to avoid breakdowns and major repairs, and more efficient use can be made of maintenance men since their time can be scheduled as much as a week in advance.

MAINTENANCE CARTS

Many hospitals have found maintenance carts helpful as timesavers. Wheeled carts can be made at a very small cost and used to particular advantage in connection with electrical, plumbing, steamfitting and general maintenance work. The idea is to provide a small "shop on wheels" so that the maintenance man will have an

Mr. Brega is the superintendent of buildings and grounds at the Rhode Island Hospital, Providence. This article was adapted from a paper presented at the American Hospital Association Institute for Hospital Engineers, New York City, June 1951.

The Engineering and Maintenance department is edited by Roy Hudenburg, secretary of the Council on Hospital Planning and Plant Operation.

adequate supply of small tools and materials with him, and will not have to make frequent trips back to the shop.

The electrician's cart, for example, could contain assorted bulbs, fuses, plugs and fittings. This arrangement ties in very well with the preventive maintenance program mentioned previously. Care should be taken to keep the carts as noiseless as possible. Rubber-tired wheels should be used. Tools and supplies should be stored in such a way as to reduce rattling.

Although all areas of maintenance activities are equally important, a detailed analysis of problems and solutions in one area, such as maintenance of the electrical system, provides illustration of the thinking involved. First, the problems: Those which have repeatedly come to my attention over a period of years can be classified as follows:

▸ *Service equipment:* Service equipment dirty or poorly maintained; service wires overloaded.

▸ *Open wiring:* Wires bare or insulation badly deteriorated; wires not properly separated from each other or from metal pipes or other objects; wires not properly supported or protected from mechanical injury; outlet boxes missing; wires not separately bushed when entering enclosures.

▸ *Conduits and raceways:* Badly deteriorated conduit or raceway; conduits or raceways not securely fastened in position; conduits or raceways not properly secured to outlet boxes, cabinets and other equipment; outlet box covers missing; overloaded conduits and raceways.

▸ *Armored and non-metallic sheathed cable:* Cable used in place of approved method of wiring; cable badly deteriorated; cable not securely fastened in position; cable not properly protected from mechanical injury when passing through floors or walls; cable does not terminate in approved fittings.

▸ *Flexible cords:* Cords badly frayed or deteriorated; cords not an approved type; cords not properly secured in sockets and attachments.

▸ *Conductors:* Conductors overloaded; unapproved or badly deteriorated conductors; joints not properly soldered or taped; two or more wires under one terminal not properly soldered or lugged; conductors subject to excessive external heat.

▸ *Outlet boxes and cabinets:* Door of cabinet does not close; inadequate covering of outlet boxes adjacent to combustible material; unused openings in box or cabinet not closed; excessive number of wires in box or cabinet.

▸ *Overcurrent production of circuits and feeders:* Circuit not protected by proper size fuse or circuit breakers; fused or circuit breakers not of approved type.

▸ *Branch circuits and receptacles:* Sufficient number of circuits not provided; circuit or feeder wires not of sufficient size; sufficient number of receptacles not provided.

▸ *Grounding:* Grounding conductors, clamps and related equipment not properly secured.

▸ *Motors:* Motors dirty or dust-covered; motors not provided with proper overcurrent protection; supply conductors exposed where connected to motor leads.

▸ *Switches:* Switches not enclosed in approved metal cabinets or boxes; switches badly deteriorated, dirty or poorly maintained; switches not of sufficient capacity; switches not properly wired; switches not capable of being locked open.

▸ *Switchboards and panel boards:* Badly deteriorated, dirty or poorly maintained board; conductors and bus bars not properly supported; switchboard or panel board not protected against moisture; switchboards or panel boards with live parts exposed to accidental contact.

▸ *Fixtures:* Fixtures deteriorated, dirty, poorly maintained or subject to moisture; fixtures not properly secured; exposed or bare conductors in fixtures; lamp guards missing where required; sockets defective; sockets in closets not located on ceiling or wall above door.

▸ *Electrical appliances:* Appliances not approved or without evidence of being properly constructed and properly wired; approved outlet not provided for appliance.

▸ *Resistance devices:* Rheostats not isolated from combustible material; rheostats not properly enclosed.

One suggested method for preventive maintenance of the electrical system would be the following:

Worksheets would be provided for the various sections of the electrical system. Their use would assure uniform practices by the maintenance personnel.

Each workshop would list the necessary inspections and services for a particular section of the electrical system, identifying each section by an item number. A rectangular check space in the time schedule columns alongside the list could illustrate the minimum frequency for performing each operation.

The electrician would be responsible for servicing equipment and for making appropriate entries on the worksheet. Before starting the inspection, he would enter his name, the date, and location of equipment to be serviced. As he completed each step in the maintenance operation, he would mark the check space with one of the following:

1. A check mark if equipment is found satisfactory.

2. A cross if adjustment is required.

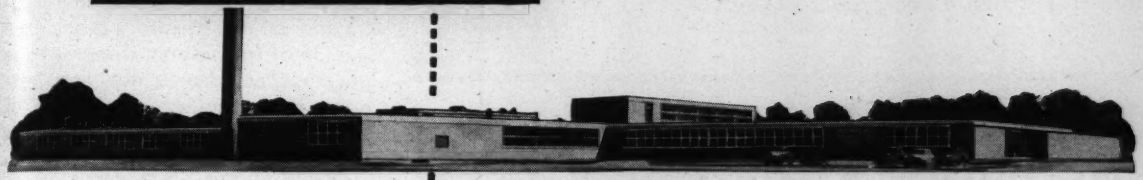
3. Two crosses if repairs or replacements are necessary.

If the defects could not be corrected immediately, or if the correction required a substantial amount of repair work, he would enter a full explanation in the space for remarks, including the item numbers and the defects involved. The electrical supervisor would then have the necessary work orders issued for the repair work.

SYSTEM PAYS DIVIDENDS

The hospital engineer will find that as the system is gradually extended, less and less time will be expended on major emergency repairs. There will be fewer breakdowns with less interference to the operating personnel, and as an end result, a smoother running hospital. Initially, the repair and maintenance staff may need to be increased, but in a short time the savings effected should more than offset the increased salary expense created by added personnel;

weather-tight



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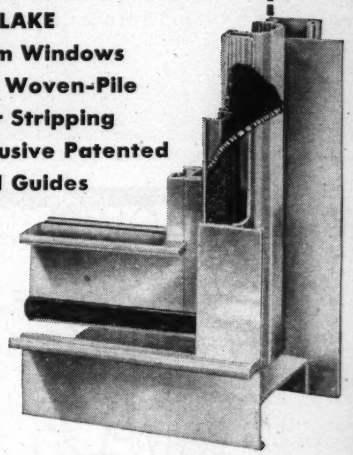

The combination of woven-pile weather stripping and patented serrated guides in every ADLAKE Aluminum Window assures minimum air infiltration and complete weathertightness—with finger-tip control—*for the life of the building!*

The ADLAKE Aluminum Windows in the new Northern Indiana Crippled Children's Hospital combine efficiency with economy—for while they keep out wind, rain and cold, they also are *paying for themselves* by eliminating all maintenance costs except routine washing!

Only ADLAKE Aluminum Windows have the combination of woven-pile weather stripping and patented serrated guides that assures a complete weather seal. And ADLAKE Windows never warp, rot, rattle, stick or swell. Their easy operation, like their good looks, is built in for life.

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later on, it might even become possible to reduce the personnel requirement to its original level in the plant.

The adoption of a preventive maintenance system will definitely pay dividends within a comparatively short time evidenced by a perceptible reduction in the number and cost of major repair items. What is more important, a substantial decline will be noted in lost time due to equipment being out of service.

ENGINEERING and MAINTENANCE COMMENT

"How to do it" plans

DETAIL SHEETS showing how to build 117 different items, such as safety racks, welding screens or broken glass disposal cans, are available from the National Safety Council. To select the sheets wanted, write the council for its new "List of Detail Sheets." The sheets sell at 24 cents each with a special discount for quantity orders and also a discount for subscribers to the "Hospital Safety Service."

Floor maintenance manual

Among the many floor maintenance manuals, a new one in a pocket-book size competes for high honors (11E-1)*. It is a concise, authentic presentation that covers many types of floors and makes reference to specified materials in general terms only, rather than through trade names of products manufactured by the company publishing it.

Non-slipping fabric

A mineral coated fabric that can be applied to walkway surfaces with waterproof cement is ideal for shielding hospital ramps against slipping hazards (11E-2)*.

The material is available in four different colors and in a variety of sizes. While ramps are the most dangerous type of hospital walkway in regard to slipping hazards, marble stairs, areas around kitchen ranges and many other spots in the hospital are often equally hazardous and can be protected by this material.

Pest control

House flies that have developed an immunity to D. D. T. are being controlled in Great Britain by a new chemical. The material, which is not yet available in the United States, is said to be more selective in its action than D. D. T. and not as harmful to other insects.

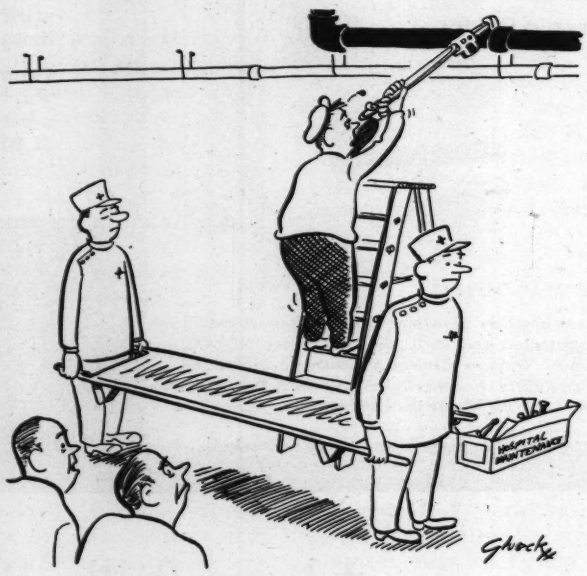
The "Pest Control Manual" prepared for the American Hotel Association by the York Research Corporation of Stamford, Connecticut, refers to the flies which have developed a D. D. T. resistant strain as "wild" flies. This manual suggests the periodic switching of insecticides to prevent the development of immunity in flies.

The manual is also an excellent treatise on the identification, habits and control of insect pests. One section of the manual discusses the question of insecticides and another part provides "Evaluation of Mothproofing Compounds." This section discusses both short term and long term mothproofing compounds (the latter contain silico fluoride). Ten selected mothproofing compounds are discussed in the report.

Baseboard heating unit

Baseboard radiation now available consists of a convector in a simple sheet metal inclosure formed to resemble a conventional baseboard. Two styles are available: One in a semi-recessed type, the other having an over-all projection of approximately two and a half inches, for use where recessing is impractical.

The assembly has a rating of 370 B.T.U.'s per hour per lineal foot with hot water circulating at 170° temperature. In using steam, the



"Not too sure of himself, is he?"

*Readers desiring to know the names of the firms manufacturing or distributing the products described should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10. For convenience, list the code numbers that follow the items about which information is requested.

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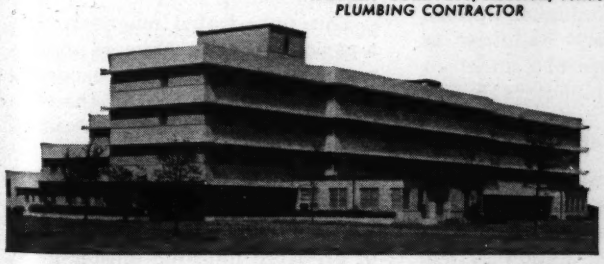

AND MANY, MANY OTHERS

You too can count on Crane *Duraclay* for outstanding service. For *Duraclay* is a superior vitreous glazed earthenware material developed primarily for hospital fixtures and thoroughly proved in the nation's leading medical centers. Specify Crane *Duraclay* with complete assurance that it will resist abrasion acid, stain and thermal shock. See your Hospital Purchasing File for a recommended list of Crane *Duraclay* plumbing fixtures. Make selection through your Crane Branch, Crane Wholesaler or Local Plumbing Contractor.

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PLUMBING AND HEATING

heating output is equal to 2.4 square feet of radiation per hour per lineal foot. A descriptive pamphlet is available (11E-3)*.

New air filter

A ventilating equipment air filter, originally designed for the use of the Atomic Energy Commission, is said to remove 99.98 per cent of all dust, fumes, and particles from the air (11E-4)*.

The filtering material is a soft, felt-like paper made of an especially treated pulp containing asbestos fibers. The paper is packed into the filter in an accordian pleat arrangement to provide a greater filtering area within a smaller space than is ordinarily required for air conditioning equipment. The filters, measuring 24" x 24", are available in sizes for the delivery of 500 cubic feet per minute and 850 cubic feet per minute.

The filter is not intended for use in ordinary installations, but is particularly applicable to uses where completely clean air is required, or in areas where radioactive particles might otherwise be discharged into the atmosphere.

Hospital elevator needs

Hospitals considering replacement of obsolete elevator equipment will be interested in a new booklet now available (11E-5)*. This booklet describes elevator traffic problems, automatic dispatching systems, elevator sizes and dumb-waiter equipment.

Cellular glass insulation

While discussing well-illustrated booklets, one should not overlook a booklet on cellular glass insulation which is also available (11E-6)*. This insulation is made in a wide number of shapes and thicknesses to permit a variety of applications over rounded objects such as pipes and tanks. The pipe insulation is factory-wrapped and ready for painting on the job.

Wall-hung telephone booth

The public telephones on the waiting room floors of the hospital are a great convenience, but frequently they are omitted to save the floor space occupied by a conventional telephone booth.

There is available now a wall-

hung type of doorless telephone booth which has sides and back treated with an acoustical material to insure privacy and to cut off interfering noises (11E-7)*. This type of booth might also be considered for locations on the floor where physicians usually take calls received over the hospital switchboard.

Air-conditioning booklets

A new booklet, recommended for the administrator, deals with air conditioning (11E-8)*.

This is not the catalog type of booklet which shows the various sizes of equipment available nor which gives technical information. It is rather the primer type of document that might be used by the administrator to demonstrate the functions of air conditioning to a non-technical committee. It simply and graphically describes the various processes that can be applied to air in order to make it more comfortable, more healthful or better suited to some particular operation.

Another booklet on air-conditioning equipment describes for the non-technical person the high velocity air conditioning equipment used in multi-story buildings as well as other types of central air conditioning equipment (11E-9)*.

Standard inter-com system

An inter-communicating system that offers standard equipment for either a two-station, a seven-station, or an eleven-station system is now available (11E-10)*.

This particular equipment permits the installation of the basic equipment without requiring the purchase of complete new amplifying equipment when the system is to be expanded. Another point to be considered is that the amplifying unit of this set can be removed and replaced in a matter of minutes when repairs are necessary.

Paint brush care

The pure bristle paint brush is disappearing from the market as the result of shortages in the bristle market. A bulletin from a brush company indicates that future brushes will contain a maximum of 70 per cent bristles, the remainder of the brush to be made of horse hair.

This situation, plus the high levels to which brush prices have risen, makes it imperative that the best of care be given to pure bristle brushes already in use and to all brushes put into use in the future. The proper conditioning of any bristle brush calls for suspension in raw linseed oil for 24 to 48 hours prior to use. Such conditioning not only prevents the bristles from absorbing pigments from the paint but is also said to keep bristles more flexible. After the brush has been soaked in raw linseed oil it should be washed in paint thinner and combed out thoroughly. A leaflet on care of brushes is offered by a manufacturer (11E-11)*.

Plaster failures

Hospitals that have experienced blister-type failures of plaster may find some comfort in knowing that there has been a mild epidemic of such failures.

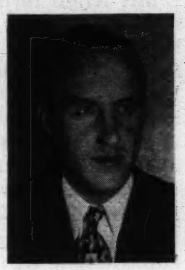
Research by the National Bureau of Standards has concluded that the failures are due to an unhydrated magnesia component of prepared finishing plaster.

This unhydrated magnesia over a period of five to 20 years absorbs water from the air, thus becoming hydrated while a part of the ceiling or wall, and eventually causes a plaster failure.

An article in the National Bureau of Standards Technical News Bulletin recommends that buyers of prepared finishing plaster insist upon "Type *S* hydrated lime that contains not more than eight per cent of unhydrated oxides." The recommendation says a statement is usually printed on bags.—R. H.

PERSONAL

JAMES I. MCGUIRE has been appointed assistant superintendent of the Western Pennsylvania Hospital.



MR. McGUIRE

Mr. McGuire is a graduate of the University of Pittsburgh and received his master's degree in hospital administration from Columbia University. He served his administrative residency at Roosevelt Hospital, New York City. Later, he became assistant director of that hospital.

Mr. McGuire is a personal member of the American Hospital Association and a nominee of the American College of Hospital Administrators. During World War II he served as an officer in the Hospital Evacuation and Professional Section on the staff of the Surgeon of Service Command at Governor's Island, N. Y.

RAYMOND W. BROOKE and ROBERT E. TOOMEY have joined the administrative staff of the Roosevelt Hospital, New York City.

Mr. Brooke is assistant director, succeeding James I. McGuire. He formerly was assistant director of the Johns Hopkins Hospital, Baltimore, and director of the Easton (Md.) Memorial Hospital.

Mr. Toomey, now administrative assistant in charge of outpatient services at Roosevelt Hospital, formerly was an administrative resident of the Hospital Council of Greater New York.

WILLIAM R. WILLIAMS, formerly assistant administrator at the University of Illinois Research and Educational Hospitals, has been appointed administrator of Good Samaritan Hospital, Sandusky, Ohio.

Mr. Williams, a graduate of Northwestern University's hospital administration course, is a personal member of the American Hospital Association.

SISTER M. WILBERTA has been succeeded as administrator of St. Francis Hospital, Evanston, Ill., by SISTER M. STEPHANIA.

Sister Stephania formerly was administrator and sister superior of St. Anthony's Hospital, Terre Haute, Ind. She is a graduate of Creighton University, Omaha, Nebr. and is a pharmacist.

Sister Wilberta has entered St. Louis University to continue her studies.

ARTHUR E. COLTRIN has been appointed administrator of the Jane G. Phillips Memorial Hospital, Bartlesville, Okla.

Mr. Coltrin, a member of the American Hospital Association, formerly was assistant director of Barnes Hospital, St. Louis.

SISTER M. FELICITAS, formerly superintendent of St. Joseph's Hospital, Belvidere, Ill., has been appointed superintendent of the Seneca (Kan.) Hospital, succeeding SISTER M. LIGUORI. Sister Felicitas is a personal member of the American Hospital Association.

LT. COL. LOUIS E. MUDGETT, Medical Service Corps, U. S. Army, now is executive officer of the Fifth General Hospital in Stuttgart, Germany.

COLONEL MUDGETT

For the last two years, Colonel Mudgett has been executive officer of the Eleventh Field Hospital in Stuttgart. He was assigned also to the 387th Station Hospital as executive officer.

Before entering military service, Colonel Mudgett spent more than 10 years in clerical and administrative positions in U. S. Public Health Service hospitals.

Colonel Mudgett is a member of the American Hospital Association.

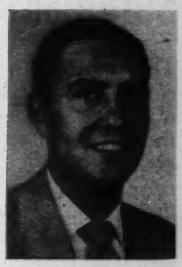
LOUETTE MACLEOD, R.N., has been appointed administrator of the outpatient department of Beth Israel Hospital, Boston. She was assistant director of the hospital before her appointment.

SAM RUTH now is administrative assistant at Beth Israel Hospital. He served his administrative residency there.

Miss MacLeod and Mr. Ruth both are members of the American Hospital Association.

J. C. FLETCHER JR. has been appointed director of the Manatee Veterans Memorial Hospital, Bradenton, Fla. He formerly was superintendent of Suwannee County Hospital, Live Oak, Fla.

H. CARL ROWLAND has resigned as assistant administrator of Spartanburg (S. C.) General Hospital and is now field representative for the Hospital and Orphan Sections of the Duke Endowment, Charlotte, N. C.



MR. ROWLAND

Mr. Rowland received training in hospital administration at the Duke Endowment. He served as hospital consultant of the hospital division of the South Carolina State Board of Health in 1948 and 1949. He is a member of the South Carolina State Hospital Association.

PAUL E. WIDMAN has been appointed director of purchasing at the Cleveland Clinic Foundation. He has been assistant purchasing agent for the Cleveland Hospital Council and assistant purchasing agent at Johns Hopkins Hospital, Baltimore.

R. ARTHUR CARVOLTH has resigned as director of the Portsmouth (Ohio) General Hospital to become the administrator of the new Miami Heart Institute, Miami Beach, Fla.

Mr. Carvolth formerly was administrator of Caledonian Hospital, Brooklyn, and before that was superintendent of the Potsdam (N. Y.) Hospital. From 1942 to 1946

he served in the Medical Administrative Corps of the United States Army.

He is a member of the American Hospital Association, the American College of Hospital Administrators and the Greater New York Hospital Association.

JAMES A. ROBINSON JR., formerly administrative assistant at the Los Angeles County Department of Charities, has been appointed administrator of the American University Hospital at Beirut, Lebanon.

Mr. Robinson is a graduate of Northwestern University's course in hospital administration and served his residency with the Los Angeles County Bureau of Hospitals. He is a nominee of the American College of Hospital Administrators.

CHARLES B. ALLEN has resigned as administrator of Monmouth Memorial Hospital, Long Branch, N. J. He was succeeded by IRA L. ERNST, who had been assistant administrator since 1948.

Mr. Allen formerly was administrator of St. Luke's Hospital, Newburgh, N. Y., and of the Springfield (Ohio) City Hospital. He also served as administrative assistant at St. Luke's Hospital. He is a member of the American College of Hospital Administrators.

Mr. Ernst was graduated from the School of Business Administration at the University of Michigan. He is a member of the American Hospital Association and the American College of Hospital Administrators.

DONALD E. HAIGHT has been named assistant administrator of Monmouth Memorial Hospital, succeeding Mr. Ernst.

MARVIN J. LAWRENCE has been appointed assistant to the executive director of the Jewish Hospital Association in Cincinnati.

MR. LAWRENCE

Mr. Lawrence received his master's degree in hospital administration from Columbia University and served his administrative residency with the Jewish Hospital Association.

For a while, Mr. Lawrence served with the Veterans Administration as a psychologist and during World War II he was with the psychological services of the Army Air Force. He is a member of the American Hospital Association and the American Public Health Association.

ELMER O. MASSMANN has resigned as superintendent of Roseland Community Hospital, Chicago, to accept the administratorship of French Hospital, San Francisco.

Mr. Massmann is a member of the American Hospital Association.

EVERETT JOHNSON has been appointed superintendent of Chicago Memorial Hospital. He succeeds JOSEPHINE BLALOCK.

Mr. Johnson is a graduate of the University of Chicago hospital administration course and served

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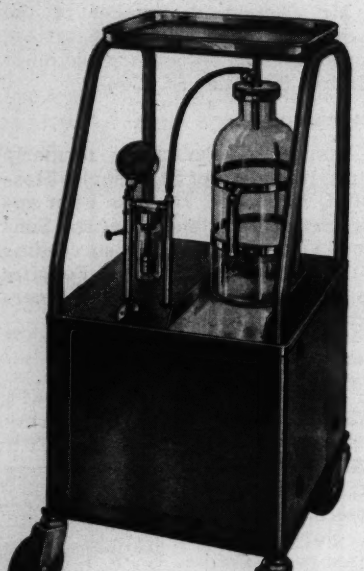

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his administrative residency at Methodist Hospital, Gary, Ind. He is a member of the American Hospital Association.

CLIFFORD S. JOHNSON has been appointed administrative assistant of Lubbock (Texas) Memorial Hospital. He is a graduate of Johns Hopkins School of Public Health, Baltimore, and was an administrative resident at Lubbock Memorial Hospital.

MARVIN W. NICHOLS has been appointed administrator of the Mahaska Hospital, Oskaloosa, Iowa, replacing C. D. KRON, who resigned.

MR. NICHOLS

Mr. Nichols received his master's degree in hospital administration from Northwestern University and served his administrative residency at the Methodist Hospital in Sioux City, Iowa. He remained at Methodist Hospital as administrative assistant until his present appointment.

Mr. Nichols is a member of the American Hospital Association.

CHARLES K. LEVINE, formerly superintendent of the Jewish Consumptives' Relief Society Sanatorium, Spivak, Colo., has been named administrator of Beth Israel Hospital in Denver.

Mr. LeVine, a member of the American Hospital Association, had served at the sanatorium for more than 15 years in various capacities.

DR. OREN A. BEATTY has been appointed medical director and superintendent of Hazelwood Sanatorium, Louisville, Ky. He formerly was at Richland Hospital, Mansfield, Ohio, as medical director and superintendent. He is a member of the American Hospital Association.

HOMER A. REID, formerly assistant director of Menorah Hospital in Kansas City, Mo., now is business manager of Lovelace Clinic in Albuquerque, N. Mex.

Mr. Reid, a member of the American Hospital Association, formerly was comptroller of Menorah Hospital before becoming assistant director.

EUGENE B. CRAWFORD JR., assistant administrator of Moore County Hospital, Southern Pines, N. C., and JOSEPH P. GREER, who has been serving a residency in hospital administration at North Carolina Baptist Hospital, Winston-Salem, have been appointed assistant administrators and instructors in hospital administration at the University of North Carolina Hospital, Chapel Hill.

Mr. Crawford served a two-year administrative internship at North Carolina Baptist Hospital.

ROBERT G. CARTER has been appointed assistant director of St. Luke's Hospital, Jacksonville, Fla.

Mr. Carter formerly was supervisor of the Hospital Division of the Florida State Improvement Commission, Tallahassee. In that

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Available in all required sizes at your Surgical or Hospital Supply House, or write direct to U. S. Stoneware Co., Akron 9, Ohio.

position, he administered the program of hospital construction grants made to Florida under the Hill-Burton Act.

He is a member of the Florida Hospital Association, the American Hospital Association, and the state and national associations of hospital planning agencies.

MOTHER NOELLA, formerly Mother Superior of St. Francis Hospital, Lynwood, Calif., has succeeded MOTHER ROBERTA as superintendent of Our Lady Of Perpetual Help Hospital, Santa Maria, Calif.

SISTER MACARIA, who has been secretary and treasurer of St. Francis Hospital, has been named Mother Superior succeeding Mother Noella.

WILLIAM DANIEL BARKER, formerly assistant administrator of the Griffin-Spalding County Hospital, Griffin, Ga., has been appointed administrator of the Winder Barrow County Hospital in Winder, Ga. He is a member of the American Hospital Association.

HAROLD E. WETZEL has been appointed administrator of the Neblett Hospital and Clinic in Canyon, Texas.

MR. WETZEL

Mr. Wetzel was graduated from the University of Alabama and completed the hospital administration course of the University of Toronto. He served his administrative residency at Memorial Hospital in Houston. Mr. Wetzel is a personal member of the American Hospital Association.

SISTER MARY ELLEN has succeeded SISTER MARY NICHOLAS as administrator of the Leila Y. Post Montgomery Hospital, Battle Creek, Mich.

JOSEPH E. BARNES, formerly assistant director of Genesee Hospital, Rochester, N. Y., has been appointed administrative officer of the U. S. Public Health Service Hospital, Baltimore. He is a member of the American Hospital Association.

Deaths

LLOYD C. FRENCH, superintendent of the South Side District Hospital, Mesa, Ariz., died recently.

Mr. French formerly was administrator of Knickerbocker Hospital in New York City and before that was superintendent of Citizens General Hospital, New Kensington, Pa. He was a member of the American Hospital Association.

LT. JOHN H. BLAKE has been reported missing in action since September 8, when he failed to return from a flight in northern Korea.

Lieutenant Blake was administrator of Wabash (Ind.) County Hospital for several years. His father, the late Edgar Blake Jr., was administrator of Wesley Memorial Hospital in Chicago before he died.

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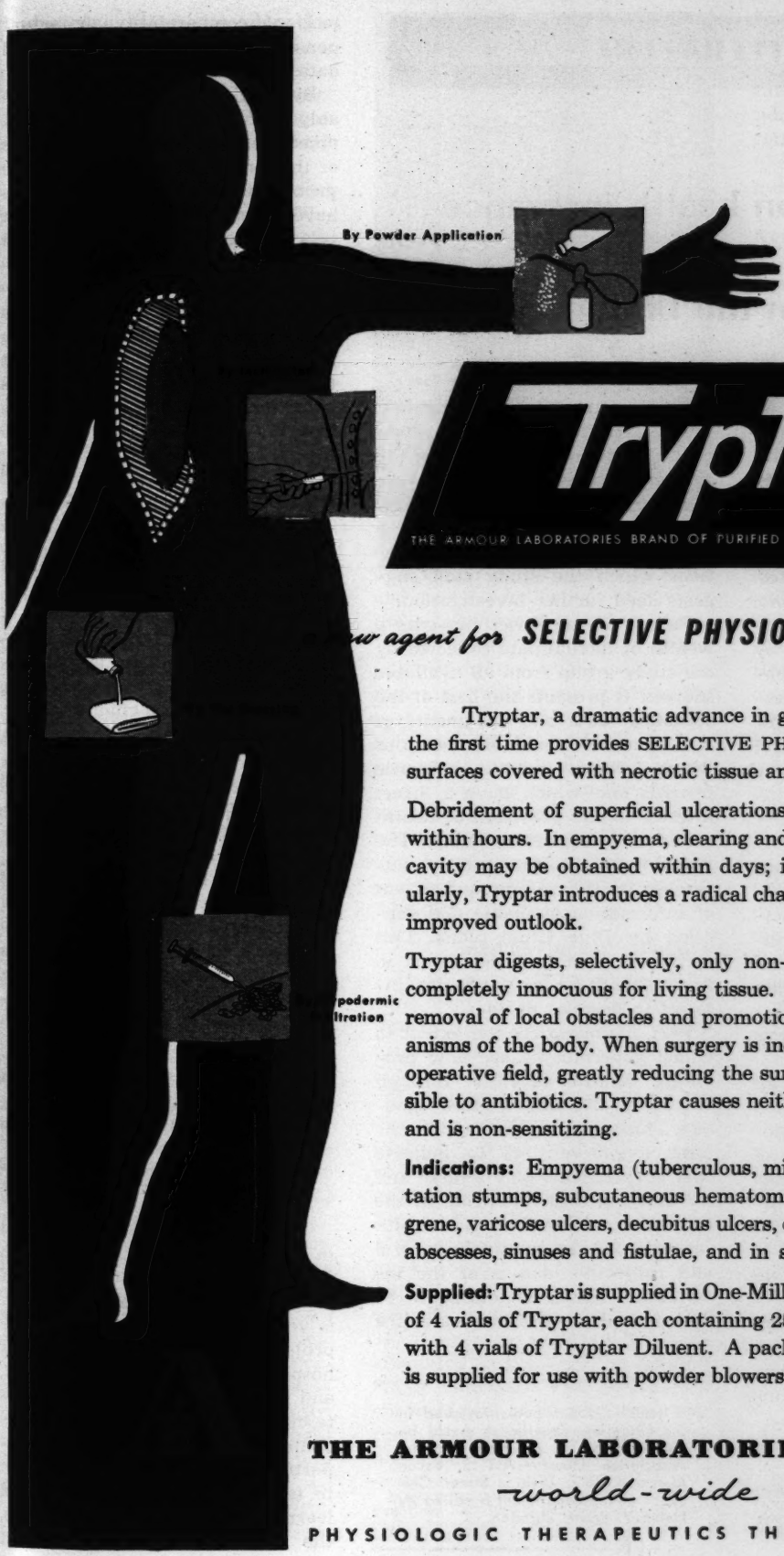

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Debridement of superficial ulcerations with Tryptar is accomplished within hours. In empyema, clearing and often sterilization of the pleural cavity may be obtained within days; in tuberculous empyema particularly, Tryptar introduces a radical change in treatment, with a greatly improved outlook.

Tryptar digests, selectively, only non-viable cells and tissues, and is completely innocuous for living tissue. Healing of lesions is induced by removal of local obstacles and promotion of the humoral defense mechanisms of the body. When surgery is indicated, Tryptar creates a clean operative field, greatly reducing the surgical risk in conditions inaccessible to antibiotics. Tryptar causes neither local nor antigenic reactions and is non-sensitizing.

Indications: Empyema (tuberculous, mixed or non-tuberculous), amputation stumps, subcutaneous hematomas, osteomyelitis, diabetic gangrene, varicose ulcers, decubitus ulcers, carcinomatous ulcers, soft tissue abscesses, sinuses and fistulae, and in second and third degree burns.

Supplied: Tryptar is supplied in One-Million-Unit shelf cartons, consisting of 4 vials of Tryptar, each containing 250,000 Armour Units (250 mg.), with 4 vials of Tryptar Diluent. A package containing plastic adapters is supplied for use with powder blowers.

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PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

Report on health insurance plans in the United States

A RECENT STUDY, conducted on order of the Congress of the United States, reports facts about the extent of coverage, the adequacy of benefits, and the relative degree of participation in various types of voluntary health insurance programs in the United States.

Basically, it is a factual report. Only well documented and reserved observations are offered by the study staff. Most of the observations are presented as questions and suggestions of need for further study of this basic social problem. It is a comprehensive source of available current information on this subject.

Dr. Dean A. Clark, general director of the Massachusetts General Hospital, served as study director for this milestone of fact-finding in the field of the individual's financing of health services. He was assisted by an outstanding supporting staff of associates, including Elling Aannestad, Morris Pike and Cozette Hapney.

Together, this group combed all available resources of information about the availability, the adequacy, the cost and the extent of acceptance of present health insurance offerings and supplemented these facts with a compilation of data concerning the extent to which governments produce and distribute health services.

All of this information is succinctly presented in the three-part report prepared for the Senate Committee on Labor and Public Welfare of the 82nd Congress.

Part 1 of the report begins with summary statements of findings. These are followed by chapters dealing with major divisions of the subject, at the end of which are comments by the authors. These comments analyze the data to a degree but primarily raise questions which the study staff suggests need further investigation.

Part 2 of the series presents a wealth of factual data collected by the study group from all available sources. It presents the best of the statistical data and judgments of all agencies and organizations which provide health insurance benefits and which have a direct interest in the provision of health care for the American public. The reader will be particularly impressed by the volume and extent of information available and supplied by Blue Cross plans. This section of Part 2 of the report in itself should be of particular interest to hospital people.

Part 3 summarizes the extent to which governments are now providing health services through various health and welfare agencies. This section of the report contains extensive data to indicate that governments play a large and increasingly important role in the provision and distribution of health services. Yet the relatively general and subjective nature of the information leaves something to be desired and probably indicates the lack of comparability or actual non-availability of governmental data on the subject.

By and large this study is probably the most complete, the most objective and the most informative of the long series of studies of the problems of health insurance which have been made during recent years. Hospital administrators and others interested in health insurance will do well to study the report and have it available as a basic reference guide for future analysis of the problems attendant to the broader distribution of adequate health services.—MAURICE J. NORBY.

*HEALTH INSURANCE PLANS IN THE UNITED STATES. 82nd Congress, 1st session. Report Number 359, Parts 1, 2 and 3. Washington, D. C., U. S. Government Printing Office. 1951.

Inquiries about books reviewed in the Literature department should be addressed to the American Hospital Association Library—Asa S. Bacon Memorial, 18 E. Division Street, Chicago 10. The department is edited by Helen V. Pruitt, librarian.

Information on fuel oil

FUEL OIL MANUAL. Paul F. Schmidt. New York, The Industrial Press. 1951. 160 p. Index, 34 tables. $3.50.

This manual provides practical information on the properties, selection, handling and burning of fuel oil. It is written in non-technical language so as to be particularly valuable to the purchasing agent as well as the chief engineer.

The text should be especially useful to the engineer who is converting his plant to the use of oil and will require background information on unfamiliar combustion problems that develop.

In view of the high proportion of operating costs that go for fuel expenditures, the sharing of knowledge by both buyers and operators (as in this manual) seems to be a matter of only common sense.—ROY HUDENBURG.

Hospital service projects

MANUAL OF OPERATION, GIFT SHOPS AND SNACK BARS. Committee on Women's Hospital Auxiliaries, American Hospital Association, 18 East Division Street, Chicago 10. 1951. 39 p. $1.50.

This second manual to be edited in the name of the Committee on Women's Hospital Auxiliaries of the American Hospital Association is very appropriately on a service project, primarily "a service to its hospitals, its patients and its staff, and it is unique in this, that the fascinating challenge of merchandising can be combined with opportunity for service." In addition to techniques given in books and learned from practical experience, the committee points out that

"knowledge, enthusiasm, devotion, business ability and a desire to serve the hospital are requisites for success in this undertaking" (that is, in operating a gift shop or a food service by a volunteer group within the hospital).

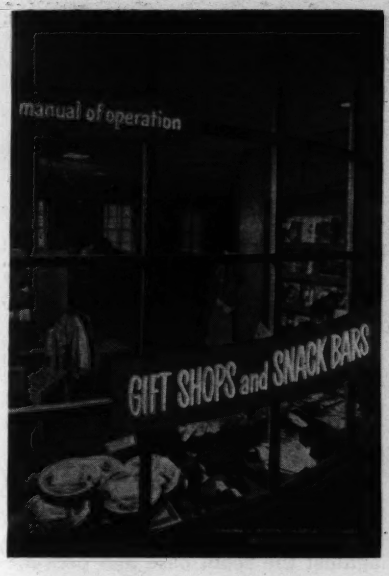
Mrs. Lee Tollefson, a former member of the Committee on Women's Hospital Auxiliaries and chairman of the gift shop committee of her auxiliary at The California Hospital, Los Angeles, prepared the original draft for the gift shop workbook. Her personal, friendly and thorough manner of work is found throughout the information. Combined with this is the added information that is given by Mrs. Abraham E. Pinanski, Women's Auxiliary of the Beth Israel Hospital, Boston, who also has operated a highly successful gift shop in that hospital.

The experiences of the West and East, including information from 80 other hospital auxiliaries which furnished detailed facts and figures, make this manual valuable to the women's hospital auxiliary considering the idea of a gift shop; for one whose operation has not been too successful, or for the one established and doing a fine business but which can learn a new trick or two for even more beneficial operation.

The original copy for the snack bar section was prepared by Mrs. Fred C. Baldwin, also a former member of the Committee on Women's Hospital Auxiliaries. She is affiliated with the auxiliary of the University Hospitals, Cleveland. For this material, Mrs. Baldwin also had the cooperation of hospital auxiliaries throughout the United States and Canada and has included the essentials needed in the operation of a food service within the hospital.

With their years of experience, the members of the committee agree with the women's hospital auxiliaries that these projects are successful from the point of view of service and convenience to hospital patients, visitors and personnel. Where they are run efficiently, they are ventures that have brought returns to the hospital in good will as well as financially.

The style of writing makes good reading. The lively illustrations



make serious information readable. The actual pictures of gift shops and snack bars bring out vividly the great variety of undertakings.

This brief description giving pointers of the "right way" may save many a disappointment on the part of the women's hospital auxiliary anxious to establish such a project; the administrator who has to say "yes" or "no" to the suggestion, and the board of trustees who will be approached for their blessings in the venture. Here are the practical answers.—ELIZABETH M. SANBORN.

Medical group practice

Three publications recently issued bring up to date the existing information on medical group practice. The Bureau of Medical Economic Research of the American Medical Association, under the direction of Frank E. Dickinson, Ph.D., has prepared a bibliography of articles, monographs and books printed from 1927 through 1950. This Bulletin No. 85[1] is a revision of an earlier bibliography compiled in 1947, but it has been completely revised, not merely supplemented with later listings. Included are 317 references; each one is briefly annotated to point up the article's major emphasis. The listings are chronological in arrangement and there is an author index which was not a part of the earlier edition. The compilers have classified the sources of the material into four categories—official medical organizations, official hospital organizations, governmental agencies, and commercial medical and hospital journal publishers and general publishers.

No attempt has been made to weight the bibliography toward any specific approach to the subject. The purpose of this reference work is to provide the student with a comprehensive guide in his search for material on this subject.

A further source for background knowledge is the report of the Public Health Service, "Medical Group Practice in the United States," written by Dr. G. Halsey Hunt and Marcus S. Goldstein, Ph.D.[2] It is a summary of recent published material and supplementary unpublished data on fees and volume of work and is a sort of follow-up of the study initiated in 1945 by the Division of Public Health Methods. This present summarization was made at the request of George W. Bachman of the Brookings Institution and is to be used in a section on group practice in his forthcoming report on availability of health services in the United States.

With text and the use of a great number of tables and charts an over-all picture is drawn of existing group practice in our country. Such aspects of the whole area of this activity as group personnel and organization, group administration and assets, income, prepayment plans, fees and volume of work are covered.

Medical Economics, a monthly magazine for the medical profession, has collected in a portfolio 12 articles it has published within the last four years on medical group practice.[3] The articles are reprints and are not bound into the portfolio. Administrative problems of a practical nature are discussed, such as housing, financing, legal points and the handling of patients. Some of the articles are written by group practitioners.

[1] "An Annotated Bibliography of Group Practice, 1927-1950." Bulletin No. 85. Chicago, American Medical Association, Bureau of Medical Economic Research. 72 p.

[2] "Medical Group Practice in the United States." Public Health Service Publication No. 77. Washington, D. C., U. S. Government Printing Office. 70 p. 25 cents.

[3] A Portfolio of Articles of Medical Groups and Partnerships. Rutherford, N. J., *Medical Economics,* Inc. 12 articles in reprint form. $2.

Bumper standardization would help reduce transport damage

PAUL F. NOCKA

TRANSPORTATION WITHIN hospitals beyond doubt results in the number one maintenance problem. Doors and walls are mutilated with such regularity that even new buildings look shopworn in a very short time.

There seems to be no concerted action toward establishment of uniform bumper heights or types or even toward inclusion thereof, and each manufacturer of movable equipment more or less arbitrarily fixes his own standards. It would be helpful if some representative hospital group such as the American Hospital Association were to take the initiative in establishing standard bumper heights and types for all movable equipment and work with the various manufacturers to incorporate these standards into their products. Such standards would in turn encourage building designers to provide adequate surface protection at standard heights. With this in mind, the following ideas are presented toward a solution to this problem.

PROBLEM OF PROTECTION

As far as corridor doors are concerned, it appears that no rules can eliminate the "push through" method of opening, because it is both quick and simple. The fact that doors suffer in the process is merely an annoying detail to the person wheeling a bed or truck. Consequently, the problem becomes one of finding a means of protecting doors from the inevitable.

As standard equipment, the caster manufacturers can supply a horizonal disc (Figure 1 on the next page), to place over bed casters. It is designed to revolve against the room base and prevent other parts of the bed from striking the wall. This revolving disc principle seems to be a good solution to the problem of damage caused at first contact with doors.

Figure 2 shows in an overhead view a bed or some other relatively wide piece of equipment making contact with a pair of double acting doors by means of these discs.

Figure 3 shows the bed opening the doors by pressure from the revolving discs.

Figure 4 shows the bed going through the doors after having opened them.

After the doors are open, it is obvious that unless a continuous side bumper is added to certain pieces of equipment the door corners will take considerable punishment by projections such as offsets, bolts and rivet heads. Even with a bumper, however, there would still be considerable friction with the corners of doors. To overcome this, it is proposed to install cylindrical rollers, Figure 6, on the doors at room base height and at stretcher bumper height, Figure 5, which in turn would revolve on the rubber bumpers as the piece of equipment is pushed through the door opening. There appears to be no such item now available, but with a guaranteed market it should not be difficult to find a manufacturer.

The stock rubber-on-metal bumper now used on some equipment, Figure 7, is perfectly satisfactory. The rubber-edged metal revolving disc, Figure 1, now available for beds and mounted over the casters, can be adapted to other mountings such as on or below bumpers, as shown in Figures 11 and 12. In most instances, bed sides as presently designed negate a side bumper, although a vertical sliding type has been developed which would slide between a bumper and the frame.

Revolving discs mounted over the casters or under the bumpers of equipment would make contact with the doors and open them to bumper width where revolving cylinders on the doors would take over and ride on side bumpers installed on the equipment.

BUMPER REQUIREMENTS

It would be preferable to have all discs and bumpers within room base height, or less than six inches from the floor, but a survey of standard equipment shows this to be impractical in some cases. For example, it hardly seems rational to apply a side bumper at base height on a bed because of cleaning complications, although one can be added at the fixed angle frame approximately 26 inches above the floor, Figure 11.

Again, because of the size of wheels on most stretchers, it would not be feasible to attach bumpers at base height, especially because most of them are already equipped with a bumper around the top, approximately 32 inches above the floor.

As a result, two bumper and disc zones, one at about four inches to six inches for base contact and the other ranging from 26 inches to 32 inches above the floor, would appear to satisfy requirements for all types of movable equipment.

Figures 8, 9 and 10 show a narrow piece of equipment such as an EKG cart making contact, opening and passing through a door. With narrow equipment where the total width over the bumpers is about two feet or less, the front of the bumper could be rounded and revolving discs would not be neces-

Mr. Nocka is a member of the architectural firm of Marcus & Nocka in Boston.

The Purchasing department is edited by Leonard P. Goudy, purchasing specialist.

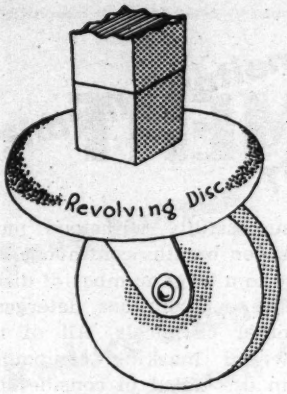
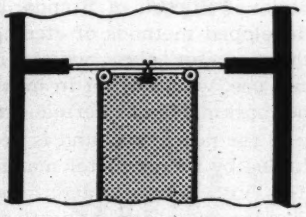


FIG. 1



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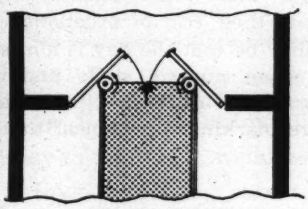

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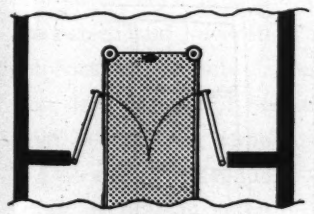

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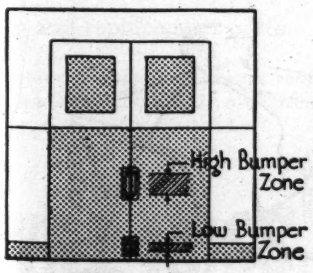

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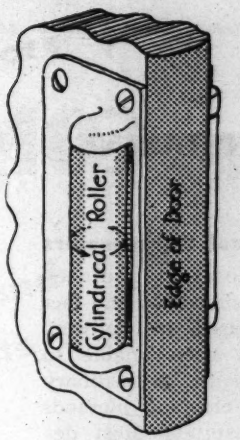

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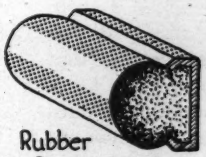

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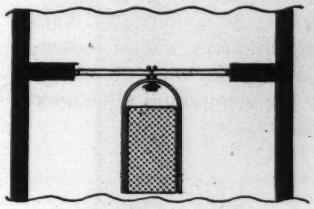


FIG. 8

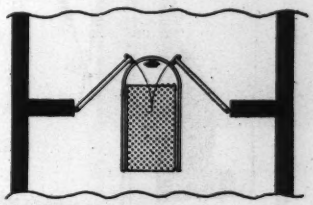


FIG. 9

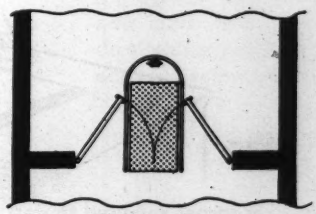


FIG. 10

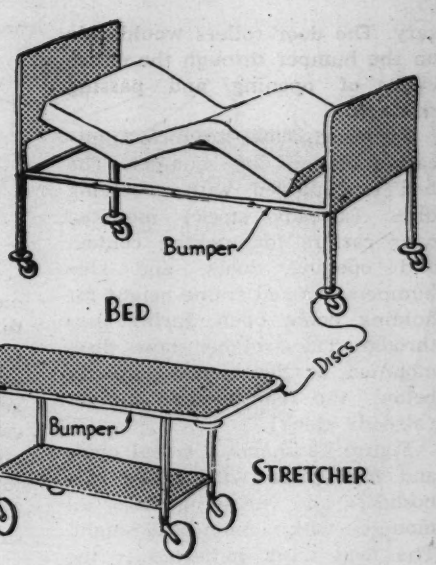


FIG. 11

FIG. 12

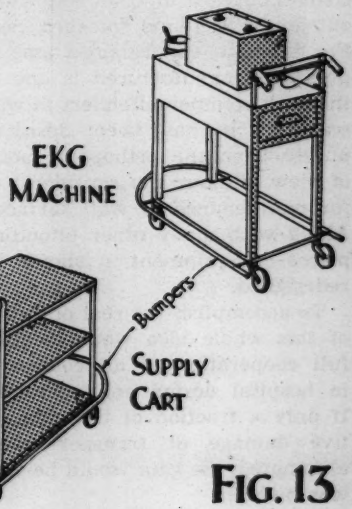


FIG. 13

sary. The door rollers would ride on the bumper through the entire cycle of opening and passing through.

Figure 11 shows a typical application of the high bumper. The bed is equipped with revolving discs (already stock) mounted over casters for making contact and opening doors, and side bumpers at fixed frame height for holding doors open during pass through. The stretcher shows discs mounted at the corners directly below the continuous bumper (already stock).

Figure 12 shows a wheel chair and food truck with added side bumpers and revolving discs, all mounted within room base height. The food truck indicated is the so-called "outdoor" model which is the only type permitting a bumper within six inches of the floor. Incidentally, this model is much more maneuverable than the standard type, and the bumpers would have to be adjusted only to the extent that they be continuous front to rear rather than stop at the wheels.

Figure 13 shows two pieces of narrow equipment less than two feet wide from bumper to bumper which, as shown in Figures 8, 9 and 10, need not be equipped with revolving discs if the front of the bumper is rounded.

REDESIGNING NECESSARY

There are bound to be some exceptions to the various standards indicated which will require special treatment, but with sufficient thought a solution can without doubt be found for each case. For example, the Balkan frame as presently manufactured is one of the most common offenders in wall scarring. It has been designed purely from the orthopedic point of view without any consideration for maintenance of wall surfaces. Along with many other offending pieces of equipment, it should be redesigned.

To accomplish the real objective of this whole idea would require full cooperation of all concerned in hospital design and operation. If only a fraction of the cumulative damage of transport were eliminated, the gain would be very worthwhile.

PURCHASING COMMENT

Clinical thermometers

MANY THERMOMETER replacements are necessitated by the fact that pigment used in marking graduations has been unable to withstand exposure to ordinary germicides and cleaning methods employed in hospitals. Most destructive of all have been soap solutions and the mechanical cleaning to which thermometers are subjected.

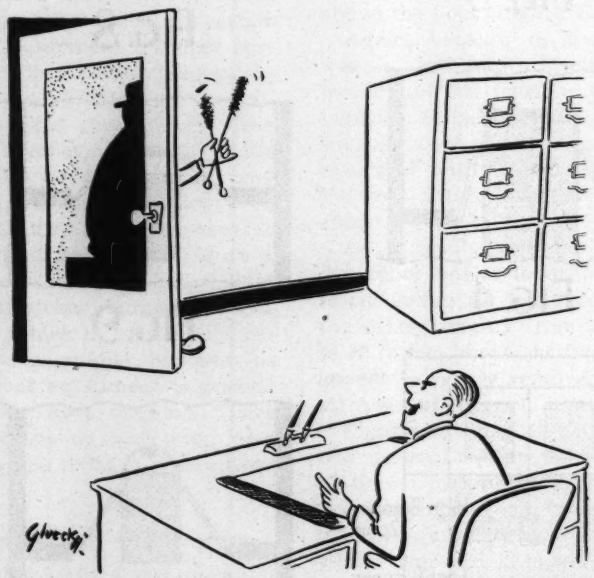
The commercial standard for clinical thermometers requires that they withstand exposure to a 5 per cent solution of phenol, but successful passing of this test has not guaranteed a lasting product.

The American Hospital Association sponsored a study at the National Bureau of Standards as a result of which a pigment containing silicone resin has been developed for use as a marking compound which gives every indication of being the answer to the problem. The compound developed has successfully withstood more than seven months continuous exposure to a large number of disinfectants, soap solutions, detergents and other chemicals. All of the commercial marking compounds now in use failed in considerably less time under the same conditions of exposure.

As part of the work being done, the National Bureau of Standards also developed methods of etching the thermometer glass which, if put into use, would assist in making the markings more permanent.

Use of the new compound is being studied by thermometer manufacturers with a view to determining whether or not its applications would be practical and whether it would necessitate extensive changes that might considerably increase their cost of production.

It may be that the day is almost past when nursing staffs find it necessary to use their lipstick to restore markings on clinical ther-



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Save Nurses' Time

Reduce Laundry and Replacement Costs

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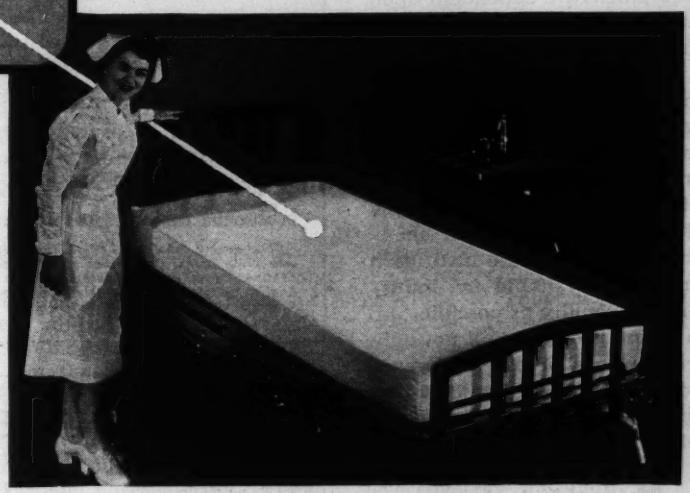
★ PACIFIC Contour Sheets are easy to put on . . . wrinkle-free and wrinkle-proof . . . stay tight and smooth . . . can't pull out . . . no mussing or bunching, no matter how often back rest and knee rest are raised and lowered . . . greater comfort for patients . . . less irritation, less danger of bed sores . . . save bed-making time and effort . . . no need for frequent straightening of bottom sheet . . . fewer sheet changes . . . less washing . . . less wear . . . actually cut both laundry and replacement costs.

Contour Sheets for hospital mattresses, made by Pacific Mills, are nationally distributed by



Less than two years ago few hospitals had even heard of Pacific Contour Sheets. Today hundreds of hospitals are using them regularly and enthusiastically. The reason for this extensive and increasing use is not advertising or propaganda or salesmanship — it is downright utility and economy. Superintendents, purchasing agents, supervisors, housekeepers, nurses, laundry managers now know from personal experience that Pacific Contour Sheets do simplify patient's care . . . save nurses' time . . . reduce laundry and replacement costs.

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mometers. If so, one of the factors contributing to inaccurate readings will have been removed.

Steel scrap shortage

It would be difficult to miss reading about the steel scrap collection program now being intensively carried on. About 300 trade associations, including the American Hospital Association, are taking an active interest in the program by appealing to their members to dig up all scrap material and make it available to industry.

A part of all steel produced comes from scrap iron and steel. The product is improved and production time is shortened when industry can use scrap materials rather than having to depend on too great a proportion of iron ore. Finished steel products may contain from one-third to one-half of scrap metal.

Hospitals have a particular interest in the collection program since production of their supplies and equipment are dependent upon an adequate supply of controlled materials. While hospitals have been assured of a high priority when allotments of steel are being made, there will be unavoidable cutbacks if the scrap collection program is not successful.

It therefore behooves all hospitals to survey all unused or abandoned equipment in the institution and make it available for industrial use as rapidly as possible.

An active program will not only contribute greatly to maintenance of production but will indicate that hospitals are making every effort to help with their own situation.

Disposable bedpan cover

A new disposable bedpan cover now is being distributed by a number of hospital supply companies (11P-1).* The cover is made of tissue paper and can be disposed of at the same time that the pan is emptied. It covers both the top and bottom of the pan and is self-opening so that the pan can be inserted quickly and easily.—L. P. G.

*Readers desiring to know the names of the firms manufacturing or distributing the products described should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10. For convenience, list the code numbers that follow the items about which information is requested.

Current price trends

CONFLICTING OPINIONS about the nation's business outlook have caused some confusion among buyers and sellers in recent weeks.

Administrative spokesmen, captained by Defense Mobilization Chief Charles E. Wilson, have repeatedly stated that serious inflation is just around the corner. In a talk delivered in Atlantic City on October 8, Mr. Wilson said: "Whereas there were no real shortages when the 1950-51 panic buying occurred, we are now entering a period when inflation pressures will be real rather than psychological."

The primary basis for conflicting views arose from the mid-summer slump in prices, as reflected in the Bureau of Labor Statistics' wholesale price indexes. Many industrial leaders, with heavy congressional support, regard the administration's warnings as unjustified anxiety and point to stable-to-falling prices of the last three months as proof.

A factor that has not yet lived up to predictions is large-volume buying for the defense establishment. Spending for defense now buys about 12 per cent of total U. S. production.

TABLE 1—UPSWING RESUMES

Weekly Index Numbers of Wholesale Prices—1926=100

COMMODITY	Sept. 19 1950	Sept. 26 1950	Aug. 28 1951	Sept. 4 1951	Sept. 11 1951	Sept. 18 1951	Sept. 25 1951	% of 9-26-50 to 9-25-51	Change 1-2-51 to 9-25-51
All commodities	170.3	169.9	176.8	176.8	176.9	176.4	177.1	+4.2	+1.7
Farm products	180.6	179.4	188.7	189.4	189.7	188.6	191.8	+6.9	+1.3
All foods	178.0	176.4	187.4	188.5	189.0	187.9	188.6	+6.9	+3.7
Textile products	161.0	162.1	168.1	166.7	166.5	163.2	160.9	—0.7	—6.7
Fuel and lighting materials	135.1	135.1	137.8	138.0	138.4	138.6	138.6	+2.6	+1.8
Metals and metal products	177.1	177.5	188.2	188.2	188.2	189.4	190.5	+7.3	+1.6
Building materials	220.8	220.4	221.7	222.1	222.3	222.0	222.3	+0.9	0.0

This weekly wholesale price index is designed as a weekly counterpart of the monthly wholesale price index. It is based on a sample of about one-eighth of the commodities in the comprehensive sample and therefore should be regarded as an indicator of price trends rather than as a final compilation. The monthly index should be used for fuller coverage.
Source: Bureau of Labor Statistics.

TABLE 2—BRIEF DOLLAR RECOVERY

Monthly Index Numbers of Wholesale Prices—1926=100

COMMODITY	Aug. 1941	Aug. 1943	Aug. 1945	Aug. 1947	Aug. 1949	Aug. 1950	July 1951	Aug. 1951
All commodities	90.3	103.1	105.7	153.7	152.9	166.4	179.5	178.0
Farm products	87.4	123.5	126.9	181.6	162.3	177.6	194.0	190.6
Foods	87.2	105.8	106.4	172.3	160.6	174.6	186.0	187.3
Textile products	88.3	97.4	99.6	141.4	138.1	149.5	173.3	168.0
Cotton goods	101.5	112.7	119.7	201.8	170.2	206.8	217.9	204.8
Fuel and lighting materials	79.0	80.9	84.8	112.6	129.6	134.2	137.9	138.1
Anthracite coal	83.3	89.6	101.8	121.7	135.9	142.1	153.5	154.8
Bituminous coal	106.3	116.5	124.7	169.9	188.8	192.5	194.6	194.6
Electricity	66.4	57.6	61.5	64.5	68.5	65.5	*	*
Gas	78.3	76.3	78.0	86.0	88.9	88.1	93.8	*
Building materials	105.5	112.2	117.8	179.6	188.3	213.9	223.8	222.6
Brick and tile	95.1	99.0	111.6	144.3	161.5	167.9	180.8	180.9
Cement	92.1	93.6	99.4	116.9	133.0	135.5	147.2	147.2
Lumber	127.5	145.0	155.3	276.9	277.4	357.6	347.1	342.8
Paint and paint materials	93.3	102.8	107.3	154.2	144.0	142.4	159.1	158.0
Plumbing and heating materials	86.8	90.4	93.4	129.4	154.7	164.6	183.6	184.6
Structural steel	107.3	107.3	107.3	143.0	178.8	191.6	204.3	204.3
Other building materials	99.9	101.4	104.3	150.1	167.3	178.7	198.1	198.2
Drugs and pharmaceutical materials	100.0	106.2	110.2	136.6	125.0	135.0	184.7	184.6
Raw materials	87.6	112.7	116.3	167.0	161.3	179.1	189.9	187.5
Semi-manufactured articles	89.5	92.9	95.5	148.8	147.9	159.3	174.0	170.0
Manufactured products	91.5	99.7	101.8	147.9	149.4	161.2	175.1	174.5
Purchasing power of the dollar	$1.107	$.970	$.946	$.651	$.654	$.601	$.557	$.562

**Figures not available at press time.*
Source: Bureau of Labor Statistics.

· · FEDERAL, ADMINISTRATIVE · ·

Salary Freeze Exemptions for Doctors

During the lapse of approximately two months prior to the opening of a new session of Congress in January, attention will be centered on executive agencies as sources of developments concerning hospitals. To be watched particularly are the various branches of the Office of Defense Mobilization for policies on subjects ranging from steel allocations to wage controls.

Early in October, the Office of Salary Stabilization issued its first official interpretation of that section of the Defense Production Act applying to compensation paid to physicians. The crux of this interpretation is that employed doctors, in order to qualify for exemption from salary "freeze" restrictions, must be on payrolls of hospitals, clinics or other institutions dispensing medical care.

The definition of "hospital" follows criteria set forth in the Hill-Burton Hospital Survey and Construction Act. The hospital must be licensed or otherwise conform to local minimum standards of operation. "Clinic" means an institution providing outpatient medical care. Physicians employed by specialized types of hospitals or clinics, such as those serving labor union members or prepayment plans, are held to be exempt from the salary "freeze." Those employed by other physicians are not exempt.

Administrators and superintendents of hospitals and clinics, as well as clinicians, come within the exemption ruling if they are physicians. Similarly included are dentists, osteopathic physicians and chiropodists, if they conform to employment practices set forth for doctors of medicine. The waiver interpretation excludes nurses, pharmacists, optometrists, dental technicians, chiropractors and others in auxiliary professions. In order to qualify for exemption, doctors must be licensed to practice in the jurisdiction where they work.

Dr. Crosby Fills Vacancy

Dr. Edwin F. Crosby, director of Johns Hopkins Hospital, Baltimore, has been appointed to fill the vacancy on the National Advisory Committee to the Selective Service System (Health Resources Advisory Committee) in Washington. The vacancy was created in August by the death of Dr. John B. Pastore, executive director of the Greater New York Hospital Council.

Dr. Crosby is president-elect of the American Hospital Association.

Veterans Hospital Growth

Thirty-five new Veterans Administration hospitals were completed in August, and 31 were in progress at that time, the Veterans Administration reported.

Veterans hospital additions and conversions through the end of August amounted to 40, while additions and conversions in progress numbered 10. Sixty-one sites had been acquired for new veterans' hospitals at the end of August, and five more sites had been approved but not yet acquired.

Federal Hospital Institute

About 38 administrators of federal hospitals are attending the fourth inter-agency institute for hospital administrators at the Federal Security Agency, Washington, D. C. The three-week institute began October 29.

The Public Health Service is host to the institute, attended by administrators of hospitals operated by the Air Force, Army, Navy, Veterans Administration, Public Health Service, and the Bureau of Indian Affairs.

Subjects to be covered at the institute are concerned with all phases of hospital operation and management, and include sessions on personnel relationships, as well as the relationships of a hospital with its community.

Outstanding speakers include Dr. Howard A. Rusk, director of the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center; Dr. Basil MacLean, director of Strong Memorial Hospital, Rochester, N. Y., and Dr. A. W. Snoke, professor of hospital administration, Yale University. Dr. Snoke is director of Grace-New Haven Community Hospital, New Haven, Conn.

Ceiling on Fringe Benefits?

Almost any day, the Wage Stabilization Board is expected to issue a ruling dealing with so-called fringe benefits received by wage earners, notably employers' contributions to premium payments for coverage in Blue Cross, Blue Shield and other health plans. Over a period of weeks in late summer and early autumn, a special advisory committee studied the question and heard testimony by numerous experts preparatory to the drafting of a report and recommendations.

The Wage Stabilization Board's ruling, to be based on this report, will state whether these fringe benefits are to be construed as equivalent of additional wages—and therefore subject to anti-inflation controls—or simply as ordinary accessories among conditions of employment. Should the latter, more liberal, stand be taken, great impetus would be given the movement for including hospital care coverage in collective bargaining contracts between management and labor.

Illustrating the growth of this movement is a statistical report issued recently by the Labor Department's Bureau of Labor Statistics. It deals with the automobile industry, covering 63 plans in which 683,000 workers are enrolled. All but three of these plans extend hospitalization benefits, either cash or service.

The great majority of the workers were covered by service plans stipulating a maximum of 120 days of hospital care with semiprivate accommodations. Less than 10 per cent of the employees were beneficiaries of cash plans. More than 650,000 were covered by plans extending hospitalization, surgical and maternity benefits to their dependents, only 215,000 of the total being protected by medical care benefits for dependents.

The volume of this coverage,

especially in the auto and steel industries, is noteworthy in view of the fact that practically all of it has come about in the last three years via collective bargaining.

Epidemic Control Service

An Epidemic Intelligence Service has been established in the Public Health Service to strengthen the nation's defenses against outbreaks of epidemic diseases.

Twenty-one Public Health Service medical officers recently completed an eight-week training course in Atlanta, Ga., headquarters of the Communicable Disease Center. The officers have been assigned posts in the newly organized service and now are in 12 states.

The primary job of the new Epidemic Intelligence Service will be to assist in the investigation of disease outbreaks that cannot be controlled with the resources of state and local health departments.

Federal Aid for 41 Areas

Forty-one areas of the country have been designated by the Office of Defense Mobilization as eligible for federal aid in defense housing and expansion of community facilities, including hospital expansion. They are as follows:

The Atomic Energy Commission's Savannah River Installation in South Carolina and Georgia; Paducah, Ky.; Arco, Blackfoot and Idaho Falls, Idaho; San Diego, Oceanside, Solano County, Camp Cooke, Camp Roberts, Imperial County, Barstow and Lancaster, Calif.; Davenport, Iowa; Rock Island, E. Moline and Moline, Ill.; Brazoria County, Lone Star, Borger, Mineral Wells, Weatherford, Florence-Killeen, Wichita Falls and Kingsville, Texas; Colorado Springs, Colo.

Also, Fort Leonard Wood, Mo.; Las Cruces and Alamagordo, N. Mex.; Wright-Patterson Air Force Base, Ohio; Starlake and Sampson Air Force Base, N. Y.; Norfolk, Portsmouth and Newport News, Va.; Wichita, Kan.; Tooele, Utah; Dover, Del.; Bremerton and Hanford-Kennewick-Pasco, Wash.; Camp Lejuene, N. C.; Patuxent, Md.; Valdosta, Ga.; Columbus and Indianapolis, Ind.; Huntsville, Ala.; Sidney, Nebr.; Bucks County, Pa.; Sanford, Fla., and Presque Isle-Limestone, Maine.

Inception of the program of expansion of hospitals and other health and welfare facilities in these areas will have to be deferred until 1952, since Congress did not appropriate funds for loans and grants to make an earlier start possible.

In Congressional hearings on the proposed appropriations, it was brought out that the administration favored allocating of $11,380,000 in federal loans and grants to stimulate building of hospitals and health centers in these defense production and military installation areas. Under the World-War II Lanham Act, with which this new program is comparable, a total of nearly $121,000,000 in combined federal and local funds was expended for hospital expansion.

Medical Corps Chief Named

Col. Robert Lee Black has been appointed chief of the Army's Medical Service Corps, succeeding Col. Othmar F. Goriup, who completed his term of office on September 24.

Colonel Black is now in the Far East Command, accompanying Maj. Gen. George E. Armstrong, Army surgeon general, on an inspection of medical activities in Japan and Korea.

Financial Aid to Hospitals

Financial assistance to hospitals was the objective of a bill introduced in Congress by Sen. Herbert Lehman (D., N.Y.) shortly before adjournment. It would authorize federal appropriations of $50,000,000 annually for an indefinite period "for the purpose of maintaining more adequate outpatient clinics in hospitals and health centers, for the early detection of diseases, for referral of persons found to be suffering to appropriate medical personnel, hospitals, clinics and agencies, and for more adequate treatment, home care services and community planning for the ambulatory sick."

Health Division Renamed

The Division of Industrial Hygiene of the Public Health Service has been renamed the Division of Occupational Health and has broadened its activities to include a number of investigations into health programs of working men and women.

The comprehensive program for additional protection of the health of American workers will investigate health hazards in the production, processing and handling of radio-active materials and radiation-producing processes.

Federal Security Administrator Oscar R. Ewing emphasized that the program of the newly named division will not be concerned solely with such occupational hazards, but will deal with "all problems affecting the health of workers."

Director of New Institute

Dr. Pearce Bailey has been appointed director of the National Institute of Neurological Diseases and Blindness, part of the Public Health Service.

Dr. Bailey is the first director of the institute, established by an act of Congress last summer as one of the National Institutes of Health.

From 1946 until the present, he was chief of the Veterans Administration's Section on Neurology and from 1948 also was assistant chief of the Veterans Administration's Psychiatry and Neurology Division. He was professor of clinical neurology at Georgetown University, and he conducted regular teaching rounds at Washington's Gallinger Municipal Hospital.

Achievement Awards

Outstanding achievement awards were presented by the University of Minnesota to two Public Health Service officers, Pearl McIver, R.N., and Dr. Herman E. Hilleboe.

Miss McIver is chief of the Division of Public Health Nursing, and Dr. Hilleboe, on leave from the Public Health Service, is New York State Commissioner of Health.

Miss McIver's citation described her as a "celebrated nurse and pioneer in the federal health services." Dr. Hilleboe is cited as an "outstanding public health administrator, significant contributor to tuberculosis control."

Medical Research Grants

During 1951 the Public Health Service, through its chief research branch, the National Institutes of Health, has awarded 3,705 grants to nonfederal institutions and individuals. The grants amount to 44,371,188, announced Federal Security Administrator Ewing.

In the fields of cancer, heart and mental disease—the leading causes of death and disability—a large number of grants were made to improve and expand teaching facilities, to train physicians in new diagnostic or treatment procedures, and to provide special laboratory facilities for the wider investigation of these problems.

Even greater sanitation
Even longer life.....

that's the "*inside story*" of the *NEW*

POLAR WARE
Stainless Steel
BED PAN

BED PANS all serve the same purpose . . . but that ends the similarity you'll find between the new Polar Ware pan and others . . . for this gleaming, highly polished stainless steel pan is fully seamless in construction. The most advanced welding process makes this better bed pan in one solid piece, free from any weld lines or fusion marks from which unsanitary cracks or check marks radiate. The inside has a satin-smooth surface everywhere. There is no area that can harbor bacteria, no concealed section that ordinary aseptic methods will not make sterile.

To this unduplicated method of construction, add the sturdy gauge stainless steel that is always identified with everything Polar Ware makes. This means a bed pan that has years of extra life in the service it delivers, one that will still be in every day use long after thinner gauge pans have been discarded and forgotten. It's good to know, too, that this improved Polar Ware pan comes your way without any premium in price, provides you with the best in bed pans at a cost that is competitive with products that fail to offer the same degree of service.

For this reason, and many more, you'll find Polar Ware carried by leading supply houses from coast to coast. Ask the salesman who calls on you, or write

Polar Ware Co. 3500 LAKE SHORE ROAD SHEBOYGAN, WISCONSIN

Harry Becker Joins Costs Study Staff

Harry Becker, director of the Social Security Department of United Auto Workers-CIO since February 1948, has been appointed associate director of the Commission on Financing of Hospital Care,

MR. BECKER

Chicago. He will assume his new duties on November 15.

While he was with UAW-CIO, Mr. Becker worked with prepayment plans, especially Blue Cross, which covers members of that labor group. Mr. Becker served as labor representative on the boards of trustees of Michigan Hospital Service (Blue Cross) and Michigan Medical Service (Blue Shield).

Before his present position, Mr. Becker was director of the Administrative Methods Unit, U. S. Children's Bureau, Federal Security Agency. He was also medical care administrative consultant, with particular responsibility for grants-in-aid medical care and public health programs of the Children's Bureau. He was largely responsible for the general administrative aspects of the Emergency Maternity and Infant Care Program during World War II, the largest medical care program for civilians ever undertaken by the United States government.

In Washington, D. C., he was associated with, and for several years was board president of, Group Health Association, a prepaid medical care cooperative.

His other former positions include technical adviser in medical care administration, Public Health Service, Bethesda, Md.; consultant in administration, Bureau of Child Hygiene, New York City Department of Health; assistant director and later director of Child Health Welfare and Services to Crippled Children, Nebraska, and director of UAW-CIO Health Institute and Diagnostic Clinic, with emphasis on industrial medicine and mental hygiene services. He has written several articles on economics of hospital care.

Award of Merit

An award of merit for its entry in the American Trade Association Executives public relations contest was presented to the American Hospital Association at the annual meeting of the ATAE in Chicago in September.

The award was received on behalf of the American Hospital Association by Lynn C. Wimmer, the Association's assistant director of public relations. Wesley Hardenbergh, president of the ATAE, made the presentation. The award was for the Association's "Telling Your Hospital's Story" public relations series, a membership service on which Mr. Wimmer has been working for the past year.

The citation for the award to the American Hospital Association reads: ". . . for its excellent services to its industry and the public and especially for its public relations program, 'Telling Your Hospital's Story,' which led to improved community-hospital relations for thousands of hospitals throughout America. By a variety of effective methods, the work of the hospitals has been dramatized to the lay public and the better understanding of the hospitals is leading to better patient care and is safeguarding the health and welfare of the nation."

Membership for Architects

Architectural firms represented on the American Hospital Association's Roster of Architects now are eligible for institutional membership in the Association, under a ruling recently made by the Association's Board of Trustees.

An initiation fee of $10 covers

AN AWARD OF MERIT to the American Hospital Association for its entry in the American Trade Association Executives public relations contest is accepted by Lynn C. Wimmer (right), assistant public relations director of the Association, from Wesley Hardenbergh, president of the American Meat Institute and a past president of the trade executives.

VERILOID* INTRAVENOUS

Immediate prolonged control of arterial tension through the intravenous route

The administration of Veriloid Intravenous to the patient in a hypertensive crisis produces—in a matter of minutes—a dramatic drop of arterial tension to normal or near-normal limits. For the first time, the physician now has available a potent hypotensive alkaloidal fraction of Veratrum capable of producing any desired degree of blood pressure reduction, with definite control of the intensity and duration of its action.

A Must for the Emergency Bag

Since Veriloid Intravenous makes possible immediate controlled reduction of both systolic and diastolic tension to any desired levels, it is indicated in the emergency treatment of hypertensive states accompanying cerebral vascular accidents, malignant hypertension, hypertensive crises (encephalopathy), and hypertensive states after coronary occlusion.

Veriloid Intravenous, a biologically standardized hypotensive fraction of Veratrum viride, is supplied in 5 cc. and 20 cc. ampuls, each cc. containing the equivalent of 0.4 mg. of Veriloid standard reference powder. Complete information regarding dosage and rate of administration is contained in the circular which accompanies each ampul of Veriloid Intravenous. Detailed literature promptly supplied on request.

*Trade-Mark of Riker Laboratories, Inc.

RIKER LABORATORIES, INC., 8480 Beverly Blvd., Los Angeles 48, California

the cost of a kit of materials consisting of current manuals and publications of the Association.

Architectural firms who lose their representation on the roster will lose their institutional membership in the Association also.

Certificate of Appreciation

A certification of appreciation was presented by the National Foundation for Infantile Paralysis in September to the American Hospital Association as representative of all hospitals that have worked with the foundation in patient care and research.

The certificate, the first of its type ever given by the foundation to a professional group cooperating in the care and treatment of polio victims, was accepted by Dr. Charles F. Wilinsky, past president of the Association. Dr. Herbert T. Wagner, director of hospital services for the foundation, presented the certificate.

The text of the citation reads: " . . . For the opportunity to combine joint voluntary efforts of American hospitals and the National Foundation for Infantile Paralysis; for the joint pooling of resources in study, education and service which has made possible new knowledge and techniques in treatment of the nation's polio patients; for the joint dissemination and integration of physical and personal resources which have helped reduce the catastrophe of polio, this citation is awarded in grateful recognition and thankfulness."

DR. CHARLES F. WILINSKY accepts a certificate of appreciation presented to the American Hospital Association by the National Foundation for Infantile Paralysis. Dr. Herbert T. Wagner (right) makes the presentation on behalf of the Foundation.

PREPAID CARE

Inter-Plan Bank Report

The Inter-Plan Bank of the Blue Cross Commission operated with a small gross gain during the third quarter of 1951. The gain was not large enough to offset operating expenses, however. Although the small gross loss accumulated during the first and second quarters was cut nearly in half by the third quarter's experience, the net operating loss was increased slightly after payment of bank operating expenses.

During the third quarter, the Inter-Plan Bank cleared 38,759 cases for a total of 273,909.5 days of care. Host plans were payed $3,627,787.95 and home plans were charged $3,632,224.10. This resulted in a gross gain of $4,436.15. During the first and second quarters, the bank showed a gross loss of $9,877.47. This loss was reduced to $5,441.32 as of September 30.

Operating expenses during the quarter were $9,687.20, resulting in a net operating loss of $5,251.05, or .15 per cent of income. Net operating loss on June 30 was $28,-401.62. For the nine-month period ended September 30, the net operating loss amounted to $33,-652.67, or .35 per cent of income.

Management Workshop

The third annual Office Management Workshop for staff members of Blue Cross and Blue Shield plans was conducted October 24-26 in Chicago. The theme of the workshop this year was "Increasing Employee Effectiveness."

Carl F. Strodel, a Chicago business management consultant, conducted the first two days of the workshop. He was assisted by Stanley G. Dulsky, industrial psychologist and personnel consultant to management, who has worked with Mr. Strodel on various occasions for some years.

The last day of the workshop was concerned with Blue Cross and Blue Shield problems and accomplishments. "This is Our Best," a program presented last year, was repeated. The program is a round table presentation by plan delegates of an operating function that each plan considers it does best.

The workshop this year was devoted to discussion of the function of supervision in an operation; the responsibility of management for proper use and guidance of supervision; the proper responsibility of supervisors for use of employees, and ways to make both the supervisor and the employee a more effective part of the operating structure.

Benefits for Steel Workers

Nearly 400,000 Bethlehem Steel employees and their dependents now are covered by Blue Shield surgical protection, it has been announced by E. A. van Steenwyk, executive director of the Hospital Service Plan of the Lehigh Valley,

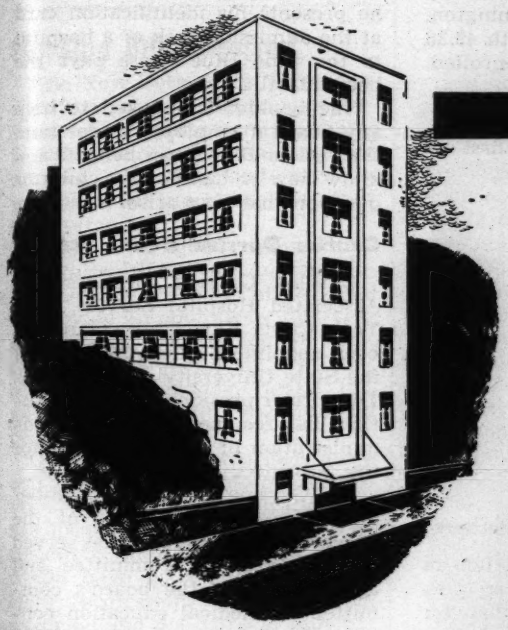
American System Spreads

E. A. van Steenwyk, executive director of the Philadelphia Blue Cross and Blue Shield (right), explains operation of modern business machines used by the plans to Dr. Herbert H. Schlink, president of the Australian Hospital Association, and Mrs. Schlink at plan headquarters.

Dr. Schlink said that when he returned to Australia he would advise his government and the voluntary nonprofit health plans already set up in Australia "to send officials over to copy the American system of prepaid hospitalization and medical care."

The Blue Cross and Blue Shield symbols already have been adopted in Australia. Dr. Schlink was made an honorary member of the American Hospital Association at its annual convention in September.

"A VERY HIGH STANDARD" of Campaign Direction



OVER-THE-GOAL AT BELLAIRE, OHIO

Campaign for City Hospital

Raised: $360,000

Goal: 250,000

RAISED 144% OF GOAL!

under Ketchum direction

"I cannot find adequate words to express my gratitude to your organization and your men whom you sent into our community to assist us."—*John Cinque, Jr., Chairman, Executive Committee of the City Hospital Expansion Fund*

"I never saw a team work better or as well as the group you sent here. Here are four men qualified to the *nth* degree."—*St. Clair Archer, President, City Hospital*

OVER-THE-GOAL AT FRANKLIN, PA.

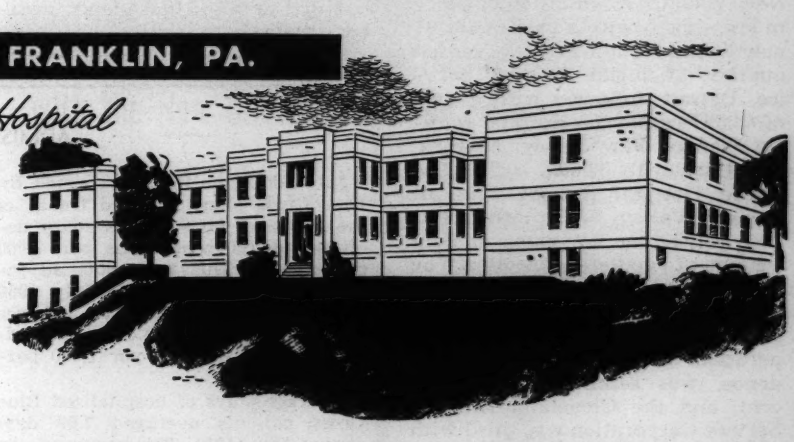
Campaign for Franklin Hospital

Raised: $570,000

Goal: 450,000

RAISED 127% OF GOAL!

under Ketchum direction



"Your staff members have been wonderful and have done a splendid job and they will be remembered in Franklin for a long time."—*W. E. Barrow, General Chairman, Franklin Hospital Building Fund*

"Your representatives conducted the campaign on *a very high standard* and always had in mind the best interests of our hospital."—*H. Carl Wasson, Secretary, Board of Directors of Franklin Hospital*

Consultation Without Obligation

KETCHUM, INC.

Campaign Direction

CHAMBER OF COMMERCE BLDG., PITTSBURGH 19, PENNSYLVANIA

CARLTON G. KETCHUM, *President* — NORMAN MACLEOD, *Exec. Vice President* — MCCLEAN WORK, *Vice President*

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MEMBER AMERICAN ASSOCIATION OF FUND RAISING COUNSEL

Allentown, Pa., the Blue Cross plan in the area.

The new benefits were added to the Bethlehem Social Insurance Program after agreement between the company and U. S. Steel Workers of America, CIO. The Bethlehem workers have been receiving extended Blue Cross benefits since Feb. 1, 1950.

"It is most gratifying," Mr. van Steenwyk said, "that our relationship with this great steel corporation's management and employees has proved so satisfactory that now the Bethlehem organization and its workers have selected Blue Shield service, offered through local Blue Cross facilities, for further protection against today's high cost of illness."

Additional Blue Cross Gain

With the addition of 553,906 new members during the second quarter of 1951, enrollment in the 88 approved Blue Cross plans reached 40,386,403 on June 30, 1951.

Associated Hospital Service of New York, the Blue Cross Plan in New York City, led all other plans in enrollment with a gain of 69,777 new members during the second quarter. Michigan Hospital Service, Detroit, followed with a gain of 65,597, while the Hospital Service Plan of New Jersey, Newark, was third with 56,899.

The Hospital Service Plan of Lehigh Valley, Allentown, Pa., now is leading the plans in percentage of population enrolled. The Allentown plan had 75 per cent of its population enrolled on June 30, 1951. The Hospital Service Corporation of Rhode Island, Providence, was second with 73 per cent, and the Cleveland Hospital Service Corporation was third with 61 per cent of the population enrolled.

Blue Shield Enrollment

The 76 approved Blue Shield plans and nine non-member plans added 1,054,175 new members during the second quarter of 1951. Enrollment in the medical care plans on June 30, 1951, was 21,094,564.

United Medical Service, New York City, led all Blue Shield plans with a net increase of 148,480 new members during the second quarter of 1951. Medical Service Association of Pennsylvania, Harrisburg, was second with 109,652, while Michigan Medical Service, Detroit, ranked third with a net growth of 74,673.

Based upon the percentage of population enrolled in the area served by Blue Shield plans, Group Hospital Service, Inc., Wilmington, Del., led all other plans with 49.38 per cent of its population enrolled.

Blue Shield Finances

The total income for the first six months of 1951 of 71 reporting Blue Shield plans and seven non-member plans amounted to $112,494,865.

Of this amount, $92,352,978, or 82.10 per cent, was used for medical and/or surgical expense. As of June 30, 1951, a total of $13,523,269, or 12.02 per cent, was used for administrative expense.

Eight Blue Shield plans paid out $1,746,795 in benefits under the veterans care program during the first six months of 1951.

Blue Cross Guide for Members

A new "Guide for Hospitals in Serving Members" has been prepared by the Blue Cross Plan for Hospital Care, Chicago, and distributed to all of that plan's member hospitals.

The guide outlines policies and procedures affecting a member of the Chicago plan from the time he presents his identification card at the admission desk of a hospital to the time Blue Cross pays the hospital bill.

The booklet is indexed to help any hospital employee understand the various Blue Cross benefits and know how to handle any claim or question that may arise.

Charles Garside Heads School

Charles Garside, president of Associated Hospital Service, New York City's Blue Cross plan, has been appointed acting president of the State University of New York. The former president, Alvin C. Eurich, has resigned to join the administration of the Ford Fund for the Advancement of Education.

Mr. Garside has been a member of the board of trustees of the university since 1948. He has served on the executive committee and as chairman of the board's committee on medical education centers. He also is a director of the Hospital Council of Greater New York.

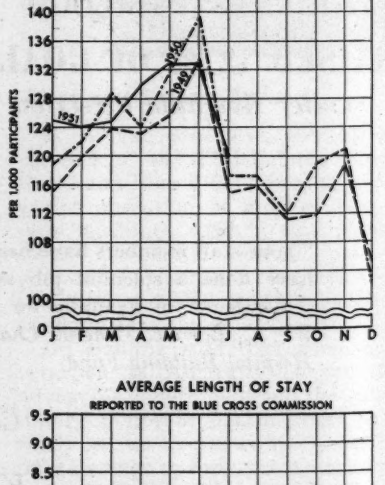
ADMISSION-STAY

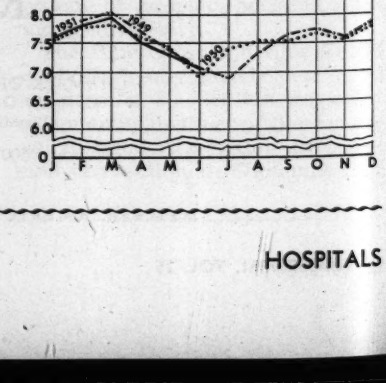
July admission figures reported by Blue Cross plans followed trends of the last two years with a sharp decrease to 120 admissions per 1,000 participants. This represents an increase of three over the July 1950 admission rate, which was 117 per 1,000 participants. The June 1951 admission rate was 133 per 1,000 participants.

Average stays of hospitalized Blue Cross patients averaged 7.09 days during June 1951. This represents an increase over the average stay during June 1950, which was 6.96 days. The average stay during May 1951 was 7.36.

Inpatient days of care given by Blue Cross plans averaged 904 per 1,000 participants during June 1951, a decrease of 61 days, or 6.32 per cent, from May 1951. In June 1950, the Blue Cross plans provided an average of 956 days of care.

Correction: In the October issue of HOSPITALS, it was reported that the average stay of hospitalized Blue Cross patients averaged 7.36 days during May 1951, an *increase* of .18 days over April 1951. The average stay during May actually was a *decrease* of .18 days from April 1951, when the average stay was 7.54 days.





· NURSING ·

Nursing Bill Opposed

The New York State Nurses Association voiced "unanimous opposition" at its recent convention to S. 337, governing federal grants to nursing education, and gave its wholehearted support to the pending Bolton Bill.

S. 337 is designed to amend the Public Health Service Act and Vocational Education Act of 1946, and to provide an emergency five-year program of scholarships for education in the fields of medicine, osteopathy, dentistry, dental hygiene, public health and nursing professions.

One of the chief criticisms given was that the bill contained a provision for an appropriation of $10,000,000 for grants for construction and equipment that would have to be divided among eight professions ranging from medicine and dentistry to nursing. In the Bolton Bill, known as H.R. 2707, a grant of $5,000,000 would go solely for nursing education.

Disaster Nursing

Nursing schools throughout New York state have been urged to include courses in disaster training for nurses by Mrs. Beatrice C. Kinney, president of the New York State League of Nursing Education.

Mrs. Kinney reported that a state-wide teaching program in disaster nursing is getting under way immediately, and that the 114 nursing schools in the state were being encouraged to alter their programs.

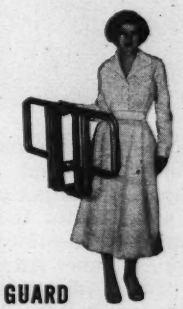
The plan for teaching disaster courses would be developed first through regional conferences for faculty members in the schools of nursing. A manual on disaster nursing is being prepared under the auspices of the National League of Nursing Education and will be used for the state courses. The manual will cover the experiences of the Red Cross nurses in the recent Midwest flood and will also deal with evacuations to shelters, births, mass diets, sanitation problems and disease prevention.

Mrs. Kinney predicted that the disaster program would give impetus to home nursing courses and that nurses would be needed to teach families self help and neighborly help as part of civil defense.

REDUCE BED FALLS

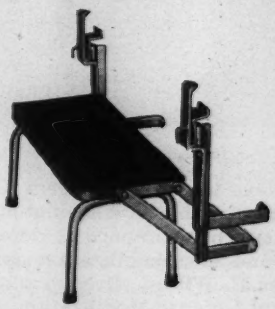
with the New Hill-Rom Side Guard and Safety Step

Here are two new Hill-Rom "firsts," designed especially to help reduce bed fall accidents. These new items incorporate many new safety and convenience features that have been thoroughly tested in hospitals, and proved to be highly efficient and satisfactory. Used on every bed in a nursing unit, these new Hill-Rom "firsts" will prove important factors in the reduction of bed falls. Illustrated literature and complete information will be sent on request. Hill-Rom Company, Inc., Batesville, Indiana.



NEW SHORT SIDE GUARD

Attached to head end of bed. Most hospitals find it will take care of 98% of all cases needing side guards. Light weight, (7 lbs.) easily attached and adjusted. Can be used on any bed—wood or metal. Does not interfere with use of over-bed table, nor with nurse making up the bed.



NEW SAFETY STEP Easily attached to either side of any hospital bed. There is no strain on the side rail. Entire weight is carried on the floor. Routinely the step should be kept in the down position. When doctor or nurse approaches the bedside, step is easily raised out of the way with a touch of the toe.

HILL-ROM COMPANY, INC., BATESVILLE, IND.

Conservation of Scarce Materials

In an attempt to ease the critical shortage of structural and reinforcing steel and other controlled materials used in building construction, the Defense Production Administration has adopted a program devised by its conservation coordinating committees to conserve scarce materials and therefore allow for more construction in 1952.

To accomplish this, a set of standard design practices was recommended by the Facilities and Construction Bureau of the National Production Authority, Department of Commerce, for use by architects and engineers in the construction industry.

The NPA has recommended the following seven design standards as good practice, considered acceptable to most engineers, architects, building officials and municipalities:

1. Where it is definitely necessary to design with structural steel, the design should be based on the "Specification for the Design Fabrication and Erection of Structural Steel for Buildings" (Revised June 1949) of the American Institute of Steel Construction, 101 Park Avenue, New York City.

2. Where it is advisable to design with reinforced concrete, the design should be based on the "Building Code Requirements for Reinforced Concrete" (A.C.I. 318-51) of the American Concrete Institute, 18263 W. McNickols Road, Detroit 19.

3. Where the design is with lumber of known grade and kind, it should be based on the "National Design Specifications for Stress-Grade Lumber and Its Fastenings" (Revised 1950) of the National Lumber Manufacturers Association, Washington, D. C.

4. All plumbing work should be laid out and scheduled to use materials not in excess of the requirements set forth in the proposed "National Plumbing Code," June 1951, issued jointly by NPA and the Housing and Home Finance Agency.

5. All electrical work should be laid out and scheduled to use scarce materials not in excess of the requirements set forth in the "National Electrical Code," 1947 edition, National Board of Fire Underwriters, 85 John Street, New York City.

6. When the design is with light-gauge steel made of cold-formed sheet or strip less than three-sixteenths of an inch in thickness, it should be based on the "Light Gauge Steel Design Manual," January 1949, American Iron and Steel Institute, 350 Fifth Avenue, New York City.

7. When floor or roof systems are designed with open web steel joists, the design should be based on the "Standard Specifications for Open Web Steel Joist Construction" (revised and adopted Oct. 20, 1949), Steel Joist Institute, 1346 Connecticut Avenue, N. W., Washington 6, D. C.

The NPA has stated that architects and engineers should recognize and incorporate in construction designs, where suitable, the many practices for conservation of critical materials. Some of these are: (1) For many types of structures, savings of approximately 50 per cent in steel content are indicated when reinforced concrete replaces structural steel. (2) Additional savings in steel can be made by designing with timber instead of structural steel or reinforced concrete. (3) In many cases,

"Scrappy" Helps Defense Drive

"Scrappy" is doing his part to help solve the scrap problem. Last month he went to Washington to help launch an important defense drive and met mobilization chiefs Charles E. Wilson, director of the Office of Defense Mobilization, and Manly Fleischmann, administrator of the National Production Authority.

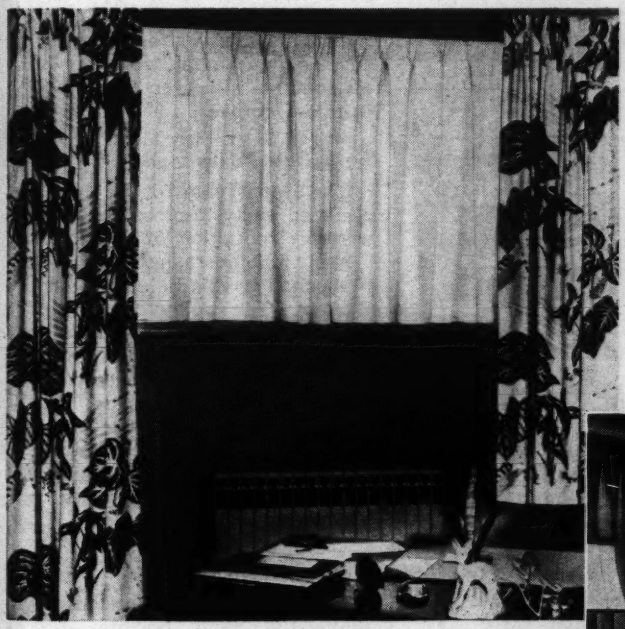
"Scrappy" is the symbol of a nationwide advertising campaign to "get out the scrap." In the mobilization for national defense, "Steel is king; and scrap is crown prince," said Mr. Wilson. It is reported this year alone the steel industry will need 36,000,000 tons of scrap to keep up with the nation's military requirements and still maintain reasonable civilian production.

United States business and industrial publications, through the Business Paper Advisory Committee of The Advertising Council, recently opened the first phase of a voluntary campaign to get scrap metal for defense.

In the photo are (left to right): Robert D. Mossman, manager of advertising, Jones & Laughlin Steel Corporation and volunteer coordinator of the council's campaign; Mr. Wilson; "Scrappy"; Mr. Fleischmann; T. S. Repplier, president, The Advertising Council.

Goodall Fabrics #1 Choice

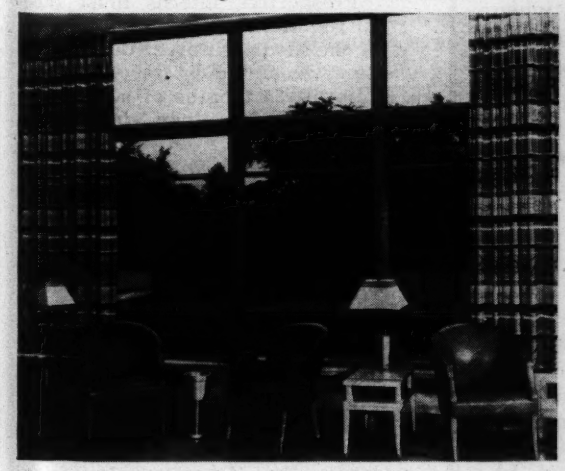
for economy and luxury in South Chicago Community Hospital



Goodall Fabrics' White "Embossed Diamond" casements and Chamois "Noa Noa" drapery fabric decorate this handsomely designed administrative office.

HOSPITALS find economy in the low-cost maintenance and longer wear... luxury in the beauty and rich textures of Goodall Fabrics. For they're *Blended-to-Perform:* created from a variable blend of Angora Mohair for resilience and texture, rayon for subdued lustre, wool for body, and cotton for durability. Choose Goodall Fabrics... get the added advantage of their noise-muffling quality... the therapeutic value of their harmonious colors.

Goodall Fabrics' "Hollyhock" drapery fabric and Dusty Rose "Crepe Mohair" casements are color-coordinated with Wine "Molano" upholstered chairs in the nurses' sumptuous lounge.



Goodall Fabrics' Inca-Brown "Cadenza" drapery fabric sets the color theme of the graciously appointed lobby... with gigantic columns covered in Goodall's Sage color Redo Plastic.

Hospitals Everywhere Get Longer Service, Lower Maintenance, Richer Beauty with

Goodall Fabrics
Subsidiary of Goodall-Sanford, Inc.
THE FINEST NAME IN FABRICS

Goodall's Specialized Hospital Fabrics:

- Goodall Draperies
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- Goodall Slipcovers
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the installation of elevators, elaborate ventilating, air conditioning, cooling systems and such equipment can be deferred until materials are more plentiful.

The NPA believes that general adoption of conservation practices and policies will permit relatively more construction in the future.

Metal Shortages Increase

Steel allocations for the first quarter of 1952 by the Defense Production Administration disclose that hospital construction projects throughout the country are in for difficulties. A total of 64,123 tons was allocated, the greater part of which will go to projects already under way, according to Public Health Service's Civilian Health Requirements Division. Unless supplemental allocations are made later, it is estimated that more than 300 new projects that were to begin this fall and in the first quarter of 1952 will have to be postponed.

Even more serious is the copper shortage. For use in construction of hospitals, 2,583,000 pounds were allocated, an amount that is far from adequate to fill requirements, according to officials.

Manufacturers of scientific and technical instruments and supplies were informed at the same time by DPA that, for the first quarter of next year, they may use no more than 45,490 tons of steel, 40,380,000 pounds of copper and copper alloys, and 13,000,000 pounds of aluminum. Earmarkings for hospital and surgical equipment, from this overall pool, had not been decided upon in mid-October.

Induction Postponed

The Department of Defense announced early last month that the military induction of 485 Priority I medical officers had again been postponed by the Selective Service System. The delay was possible only because of a sustained volunteer rate. Further induction of Priority I medical officers will depend on the volunteer rate.

Of the postponed inductions, 333 had been scheduled for induction in August and 152 in September. Induction of these men tentatively was scheduled for late fall.

Navy Internships

The Navy has announced it will make 176 Naval hospital internships available to medical school students graduating in 1952.

Prospective interns must meet all requirements for a commission in the Medical Corps, U. S. Naval Reserve, and must serve a minimum of 24 months of active duty from the date they start intern training.

Applications will be accepted and processed in accordance with the plan for internship appointments of the National Interassociation Committee on Internships. Successful appointees will be commissioned lieutenants and will receive pay and allowances in that rank during internship.

The Navy said its internship plan has the approval of the American Hospital Association, the Association of American Medical Colleges, the American Protestant Hospital Association, the Catholic Hospital Association, and the Council on Medical Education and Hospitals of the American Medical Association. The deadline for applications is Jan. 7, 1952. Appointees will be notified in March and assigned to a hospital then.

Sure! Maintenance Men are HARD TO GET...
That's why I depend on
HILLYARD MAINTAINEER SERVICE
Why "buck" the problem when you can relax with easy-going Hillyard Floor Care. Simplified Hillyard Care substitutes "know-how" for brawn . . . easier methods save man hours of work . . . specialized chemical products perform with "behind-the-ears" thoroughness . . . when I need help—Hillyard sends along a trained floor expert to lend a hand on the job . . . his straight-from-the-shoulder advice doesn't cost me a cent.
YOU CAN'T BEAT SERVICE LIKE THAT
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QUALITATIVE. Each set of Dia-Discs contains 24 tablets in two potencies of each of these commonly used antibiotics: Penicillin, Bacitracin, Streptomycin, Chloromycetin® (chloramphenicol, P. D. & Co.), Aureomycin, and Terramycin. A *complete* diagnostic survey is thus possible for optimal therapeutic results.

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Consulting Service

Three Rochester, N. Y., hospitals are cooperating in furnishing the specialists for a consulting service on laboratory procedures and techniques that has been inaugurated by the Rochester Regional Hospital Council. The three are Rochester General, Strong Memorial and Genesee hospitals.

The new service has been planned to assist council members in standardization of laboratory procedures and to advise hospitals on any technical laboratory problems. Consultation costs are paid by the Rochester Regional Hospital Council.

Consultants will be two bacteriologists, Leo Cravitz, Rochester General Hospital, and Mrs. Alice Leahy, Strong Memorial Hospital, and three biochemists, Dr. Joseph Fiore, Rochester General Hospital; Martin Murray, Genesee Hospital, and Margaret Cushman, Strong Memorial Hospital.

Dr. J. D. Goldstein, former director of laboratories for Genesee Hospital, is chairman of the committee operating the consulting service.

Mississippi

Dr. A. V. Beacham, superintendent of Beacham Memorial Hospital in Magnolia, Miss., was installed as president of the Mississippi State Hospital Association at a meeting October 11-12 in Jackson. He succeeds Robert A. Ivy, administrator of Doster Hospital and Clinic, Columbus.

The president-elect now is J. T. Grantham, executive assistant at Mississippi Baptist Hospital, Jackson. Preston Hill, administrator of Martin Sanatorium, Picayune, Miss., was re-elected secretary-treasurer.

The association resolved to enlist the full and active participation of Mississippi hospitals in an adequate civil defense program, and to educate the public and the state legislature in the necessity of full cost reimbursement to hospitals for care of indigents.

Iowa's Executive Secretary

Marion Brownlie Dennis has been appointed executive secretary of the Iowa Hospital Association.

The new fulltime secretary is a graduate of Eureka (Ill.) College and has done social work near Pe-

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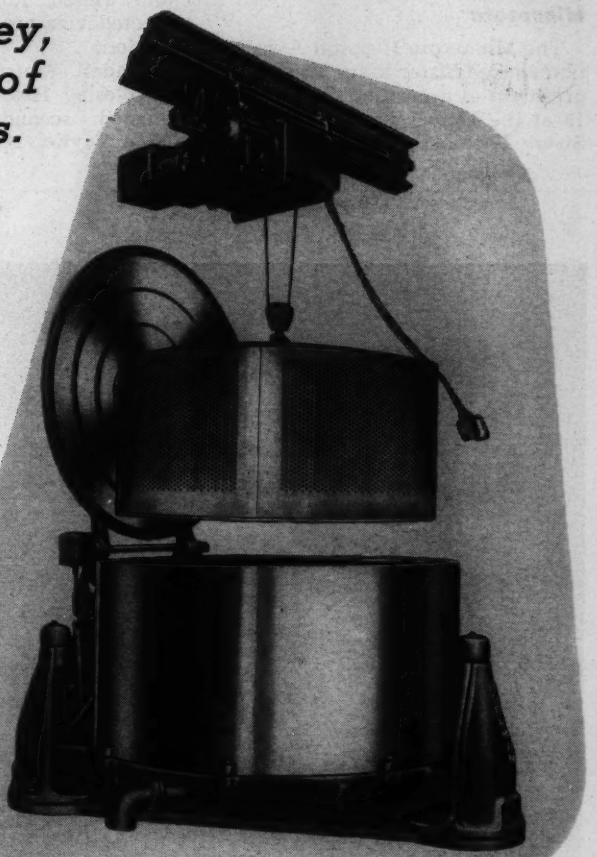

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oria, Ill., and in Marshall County, Iowa. Her hospital experience includes work in the admitting and business office at the Memorial Hospital, Elmhurst, Ill.

Minnesota

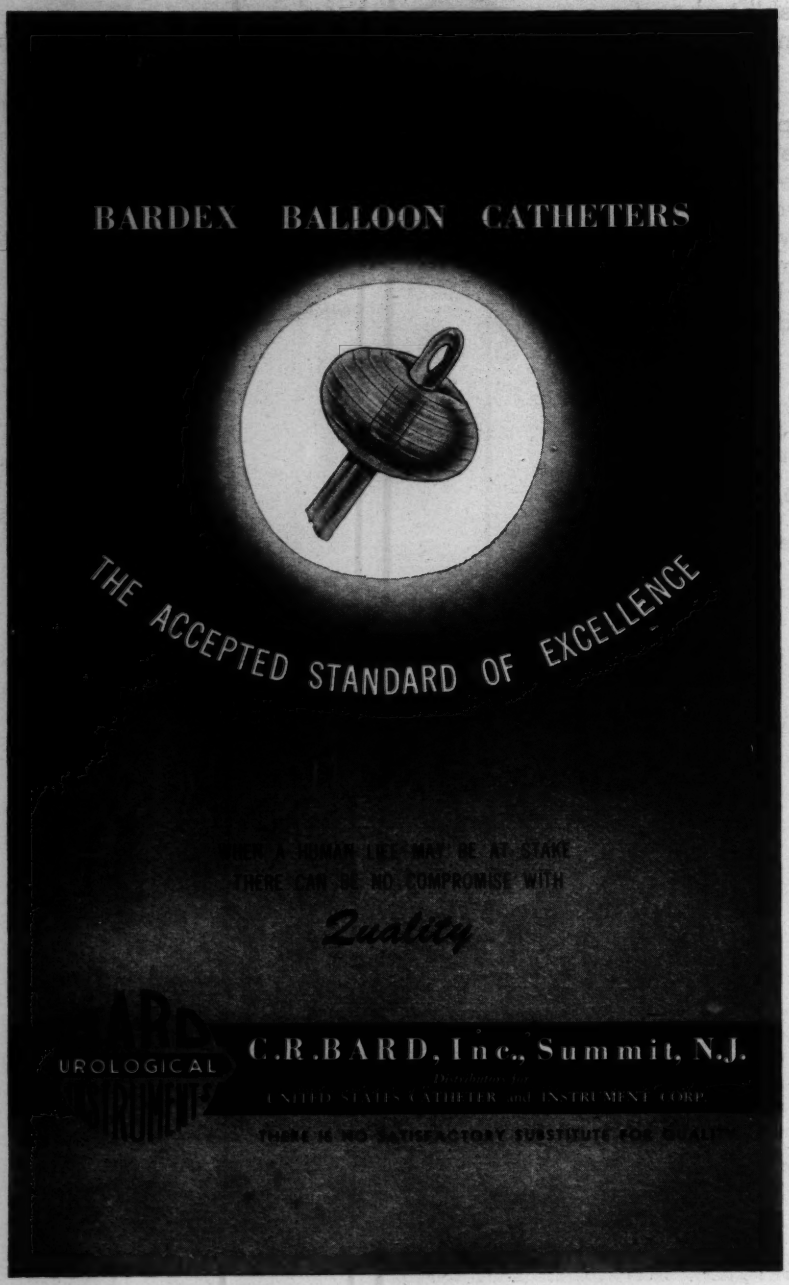
The Minnesota Hospital Association elected Sister Mary Thomasine president at a meeting October 12-13 at the University of Minnesota. Sister Thomasine is administrator of St. Gabriel's Hospital in Little Falls.

R. K. Fox, assistant administrator of St. Luke's Hospital in Duluth, was named president-elect, and Helen Rosenwald was re-elected vice president of the association.

Madell Motsiff, superintendent of Wesley Hospital, Wadena, was elected second vice president; Glen Taylor, business manager of Students' Health Service, University of Minnesota, was re-elected secretary, and W. Dayton Shields, administrator of Asbury Hospital in Minneapolis, was elected treasurer.

The association elected Alvin Langehaug a delegate to the American Hospital Association. He is administrator of Fairview Hospital, Minneapolis. C. W. Hildreth, superintendent of St. Olaf Hospital in Albert Lea, was elected alternate.

Graham Davis, director of the Commission on Financing of Hospital Care, Chicago, discussed the activities of the commission at the meeting. A second speaker, Donald Cordes, administrator of Iowa Methodist Hospital, Des Moines, explained "A Rate Structure for Small Hospitals." Mr. Cordes is also a trustee of the Upper Mid-West Hospital Conference.



Washington State

Chester Finkbeiner was installed as president of the Washington State Hospital Association during the annual convention September 11-12 at Tacoma General Hospital. Mr. Finkbeiner is administrator of the Central Washington Deaconess Hospital, Wenatchee. The Rev. Horace Turner, administrator of Deaconess Hospital, Spokane, is the retiring president.

The other new officers are: President-elect, John A. Dare, administrator of Virginia Mason Hospital, Seattle; first vice president, Mrs. Cecile Tracy Spry, administrator of the General Hospital of Everett (re-elected); second vice president, Tom Drummey, personnel director of Providence Hospital, Seattle; third vice president, Mrs. Vesta Dow, administrator of Puget Sound Memorial Hospital, Bremerton; treasurer, M. N. Olsen, business manager of the Swedish Hospital, Seattle. Mrs. Nina Mae Garner was re-appointed executive secretary. She is purchasing agent of the Tacoma General Hospital.

Topics discussed at the convention included hospital development under the Hill-Burton Act in the state of Washington; trends in nurse education; private insurance and hospital admissions, and hospital-specialist relationships.

South Dakota

The silver jubilee convention of the South Dakota State Hospital Association was held October 8-9 at Aberdeen, S. D.

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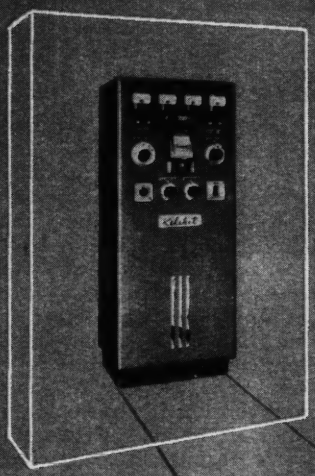

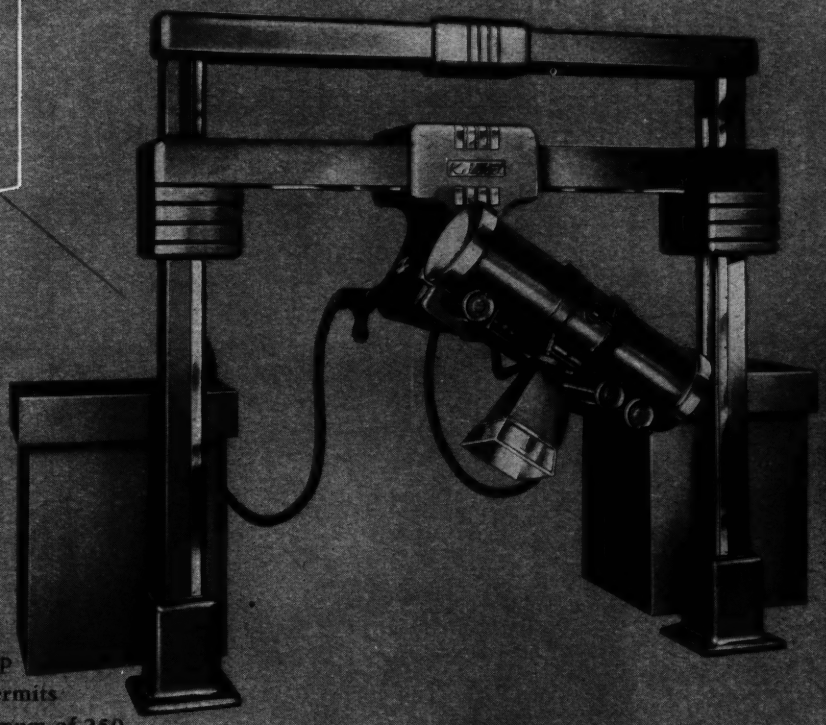

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X-Ray Tube 2 mm. Al.

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Keleket ... The oldest name in X-ray

E. E. Pengelly, administrator of the Black Hills General Hospital in Rapid City, was elected president of the association, succeeding Mother M. William, superintendent of St. Luke's Hospital, Aberdeen.

Other officers elected at the convention are: Vice president, Sister M. Innocentia, administrator of Mother of Grace Hospital, Gregory; secretary-treasurer, Edna G. Davidson, hospital nurse consultant, Department of Health, Pierre; trustees, Veronica Goebels, director of nursing service at St. Luke's Hospital, Aberdeen, and Zella Messner, administrator of Brookings Municipal Hospital.

The Rev. C. M. Austin, superintendent of Sioux Valley Hospital, Sioux Falls, was elected a delegate to the American Hospital Association.

Among the speakers at the convention were the Rev. John J. Flanagan, executive director of the Catholic Hospital Association of the United States and Canada, who discussed "Preserving Ideals in our Modern Hospitals;" and Ray Amberg, director of the University of Minnesota Hospital, Minneapolis, whose topic was the recent labor dispute at hospitals in Minneapolis. Elizabeth Sanborn, secretary of the Committee on Women's Hospital Auxiliaries of the American Hospital Association, met with the auxiliaries on October 9.

Montana

Robert D. Layng, assistant administrator of St. Vincent Hospital, Billings, Mont., was installed as president of the Montana Hospital Association at its annual meeting October 10-12 in Billings.

Mr. Layng succeeds Richard Lubben, administrator of Bozeman Deaconess Hospital.

C. K. Shiro, administrator of Montana Deaconess Hospital in Great Falls, was elected vice president, and Edwin Grafton, administrator of Shodair Crippled Children's Hospital, Helena, was elected secretary-treasurer.

Among the speakers present for the three-day convention were Dr. Anthony J. J. Rourke, president of the American Hospital Association, and the Very Rev. Msgr. Charles A. Towell, president-elect of the Catholic Hospital Association.

Dr. Emil Frankel Honored

Dr. Emil Frankel, director of the Division of Research and Statistics of the New Jersey State Department of Institutions and Agencies, has been made an honorary member of the New Jersey Hospital Association.

He was presented a citation which called attention to his service to the hospitals of the state and his work with the association on committees and councils.

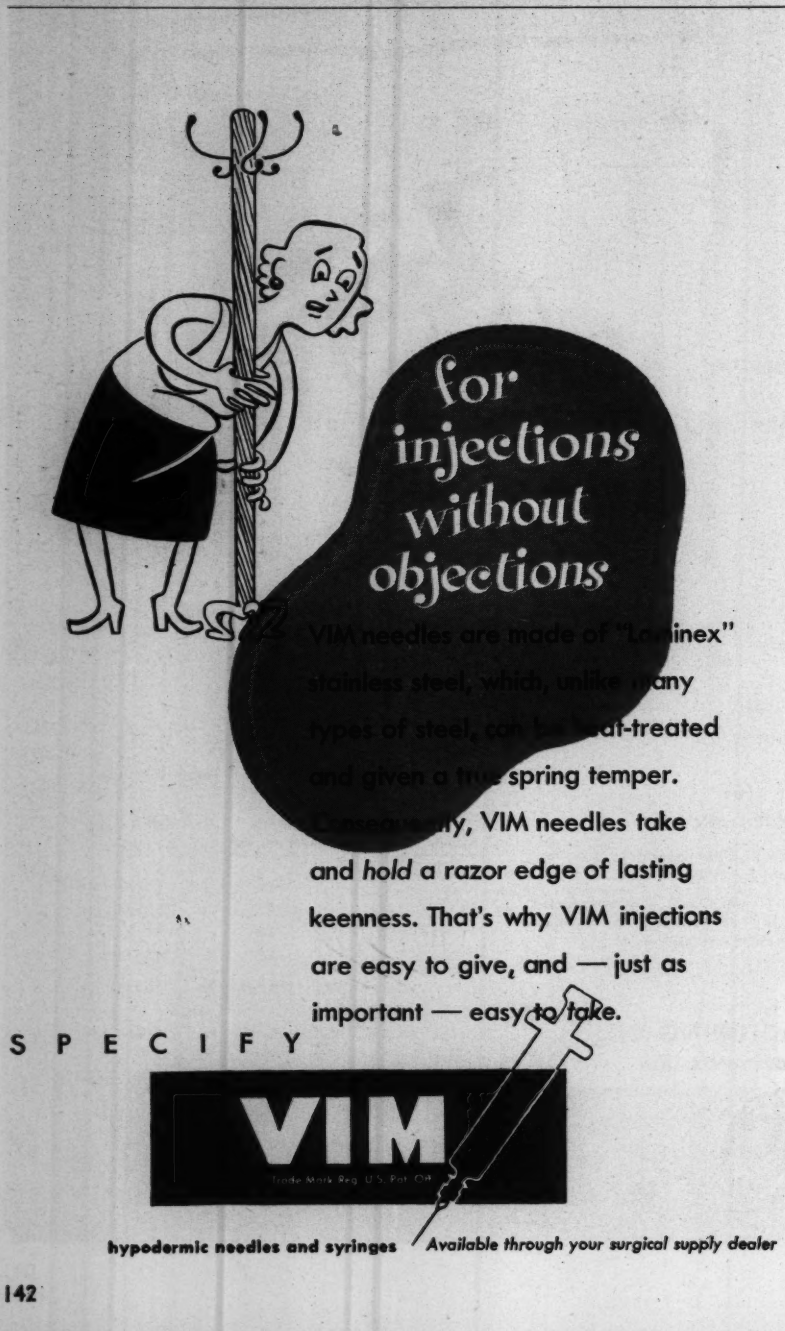
James McElroy Resigns

James K. McElroy has resigned as assistant technical secretary of the National Fire Protection Association to accept a position with a commercial firm in the fire protection field.

Mr. McElroy has been on the NFPA staff since 1945. He has specialized in building construction matters and has been interested in automatic fire alarm service.

Director of Chronic Illness

Peter G. Meek has been appointed acting director of the Commission on Chronic Illness, Chicago. Formerly assistant to the director, he joined the commission staff in 1949.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Two members of the staff of the Mt. Vernon Hospital, Mt. Vernon, N. Y., are shown as their questions are being answered by a professional service representative of Ciba.

E. Weisberger, Superintendent, Cedars of Lebanon Hospital, Los Angeles, Calif., with a Ciba Educational Exhibit in a corner of the staff room.

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Here's a time-saving method by which physicians can keep informed on new products from the research laboratories of Ciba, as well as new indications for established Ciba specialties and the latest clinical reports on these drugs and hormones. Hundreds of hospitals have welcomed a one-day educational exhibit provided by Ciba.

Only a relatively few physicians can attend the technical exhibits at medical conventions. Ciba makes it possible for you to bring such an exhibit to your hospital where it may be viewed by the entire staff at their leisure.

The Mountainside Hospital, Montclair, N. J., is one of the hospitals that has accepted this Ciba offer. Warren C. Rainier, assistant director, has reported that it is the unanimous opinion of the attending staff and everyone else concerned, that displays in his hospital have been of definite advantage to the doctors and the hospital as a whole.

A well informed professional service representative of Ciba is always in attendance at the exhibit to answer questions, but no solicitations are made and no orders are accepted. There is no disturbance in the efficient operation of the hospital and no extra work is involved for any member of the hospital staff.

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You are cordially invited to request a Ciba Educational Exhibit in your hospital. A day convenient for you will be arranged if our present schedule permits.

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Modernization and Expansion Programs

Several hospitals are increasing their capacities and improving facilities in extensive expansion and remodeling programs.

A 49-year-old shovel was used to break ground for the $2,250,000 expansion and remodeling program at St. Luke's Episcopal-Presbyterian Hospital in St. Louis.

The shovel was used on June 26, 1902, in the groundbreaking ceremonies for the original hospital building. The expansion program is being financed by a $1,000,000 fund drive. The money will supplement a $1,250,000 bequest to the hospital. Plans for remodeling include installation of new elevators and stairways in the present building, and new kitchen and working facilities adequate for a 350 or 400-bed hospital, the ultimate goal of the expansion program.

Construction of the new $250,000 Strong Memorial Wing to the Mary Harkness Convalescent Home in Port Chester, N. Y., has begun.

Under the will of William E. S. Strong, a former corporation member of the hospital, a trust was established for the construction of the wing for children needing convalescent care, and to provide an income to be used for convalescent care of child patients.

The new wing will accommodate 22 patients and will include classrooms, occupational and physical therapy rooms, a recreation room, a modern treatment room and single and multiple bedrooms. It is scheduled to be completed by June 1952.

A $4,400,000 modernization project of the 378-bed Veterans Administration Hospital in Lake City, Fla., will begin as soon as possible, the Veterans Administration has announced.

The present plant has 23 permanent buildings. Under the new project, five of the buildings will be demolished and seven will be remodeled. The hospital will contain about the same number of beds after modernization.

Newell Hospital in Chattanooga, Tenn., is planning a remodeling and expansion program to cost more than $150,000.

The program calls for construction of a new three-story wing to be built so that two more floors can be added later. It will contain emergency rooms, operating rooms, sterilizing rooms, surgeons' and nurses' dressing rooms, and the central supply room.

The old hospital structure will be remodeled and air conditioning will be installed. Modernization of the interior has been started.

Bronx Hospital Center

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Accurately hand-ground, Propper Luer Lock Tip and Luer Metal Tip Syringes are made exclusively from re-annealed borosilicate glass, formulated to provide maximum resistance to corrosion, temperature change, breakage, strain and wear. Propper craftsmen permanently attach the precision-made Metal Tips and Lock Tips. They are designed specifically to fit every standard luer hub needle to prevent leakage and to substantially reduce tip breakage. Barrels have permanent ceramic markings fused-in at annealing temperatures. Syringes are pre-tested and guaranteed against leakage and backflow.

Propper Quality Glass Tip Syringes are made from finest glass and careful workmanship insures a closely fitting luer taper. Tip breakage due to imperfect fit is thus held to the absolute minimum. Fit all standard luer hub needles. Order Metal Tip, Lock Tip and Glass Tip Syringes today. ***A sample syringe sent at your request.***

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MALDEN HOSPITAL
MALDEN, MASSACHUSETTS
BERTRAM E. GREEN,
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WYOMING VALLEY HOSPITAL
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M. CLARK JOHNSON, M.D.,
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Goal	$500,000
Subscribed	$475,000

ST. JOSEPH'S HOSPITAL
PATERSON, NEW JERSEY
THE MOST REVEREND
THOMAS A. BOLAND, S.T.D.,
President, Board of Governors

Goal	$750,000
Subscribed	$700,000

ST. JOSEPH'S HOSPITAL
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J. TURNER MOORE, Jr.
Chairman, Corporation Committee

Goal	$1,500,000
Subscribed	$1,510,000

NORTHEASTERN HOSPITAL
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GEORGE R. DURANG, *Treasurer*

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Subscribed	$435,000

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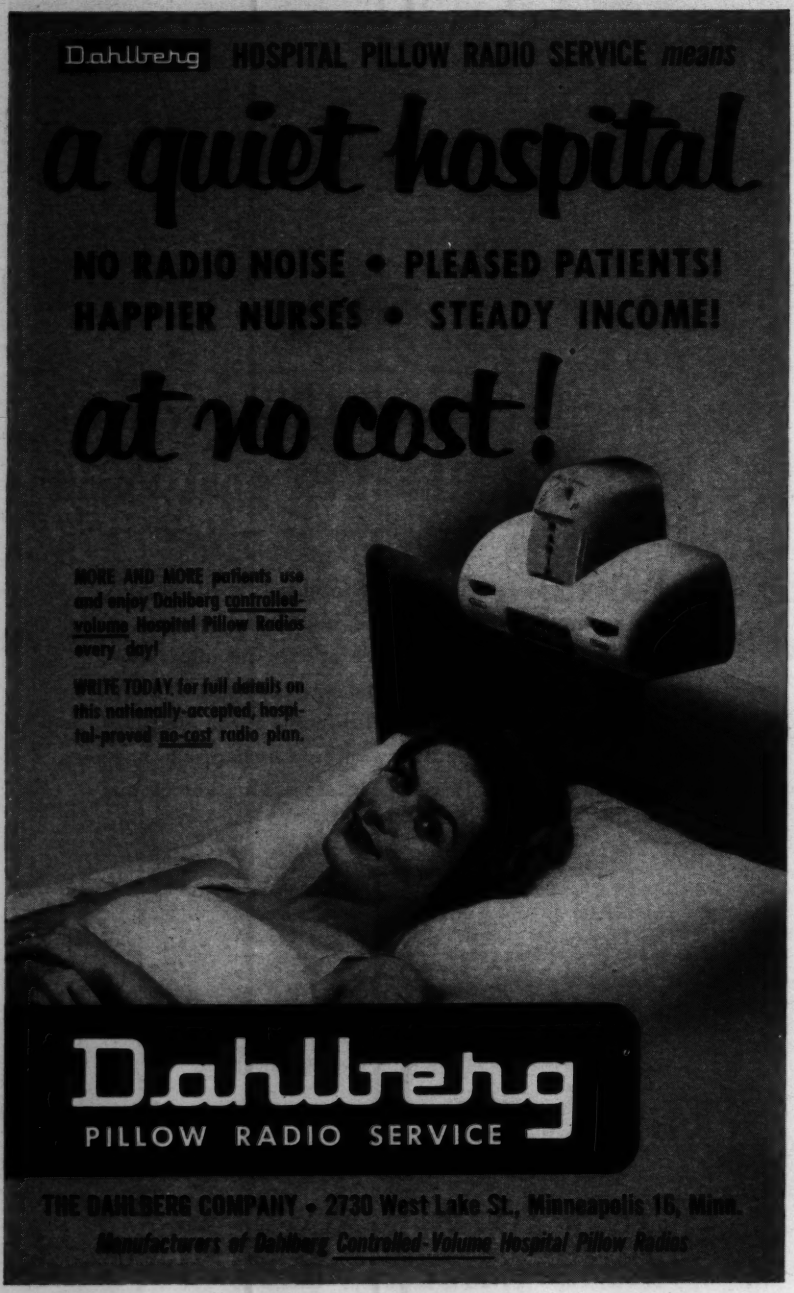
tals' new 500-bed tuberculosis hospital was laid October 18 in the Bronx. The hospital is the first unit of the Bronx Municipal Hospital Center.

It is the first large hospital to be built by the city of New York in the Bronx proper for more than 20 years. It will be named the James Alexander Miller Hospital in memory of the late Dr. Miller, who was one of the country's foremost authorities on the treatment of tuberculosis.

The seven-story hospital will cost $15,000,000.

A general care hospital, for which ground will be broken soon, will comprise the rest of the Bronx Municipal Hospital Center. The general care hospital will have a capacity of 750 beds. The estimated cost of the center's two main units, with that of auxiliary buildings, is $36,438,100. It will be financed with funds exclusively from a $150,000,000 bond issue.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Hospital Dedicates New Wing

Dedication ceremonies for a new $2,000,000 wing of the North Country Community Hospital, Glen Cove, New York, took place in September.

The new section increases the hospital's capacity to 150 beds and provides improved technical facilities. The new wing had been financed without mortgage or government assistance, and it is completely free of debt, said H. Irving Pratt, president of the hospital's board of directors.

The three-floor addition contains bed space, modern maternity and obstetrical departments, operating rooms, x-ray and therapy rooms.

Free Services by Hospital

The Hospital for Joint Diseases, New York City, spent almost one-fourth of its 1950 budget for free services to the community, according to Willard E. Loeb, treasurer of the hospital. The services cost $449,349.

Ralph F. Colin, the hospital's president, reported that the total number of bed patients treated was 6,112, representing 118,948 hospital days of care. Of that number, 66,449 were ward patient days of care. In addition, 22,801 ambulatory patients were treated in the outpatient department during 151,384 visits, or an average of 644 visits a day. Of the total number of visits, 79,638, or 52.6 per cent, were free visits for which the patient paid nothing. The remaining 71,746 paid nominal fees of 25 cents to $1 per visit.

Dr. Jacob J. Golub is executive vice-president of the hospital, which is a member-agency of the Federation of Jewish Philanthropies.

Hospital Named for Director

Women's Hospital, Flint, Mich., will become known as the McLaren General Hospital when it is moved into its new $2,750,000 building. The name is in honor of Margaret E. McLaren, who has been superintendent of the hospital for 27 years.

Miss McLaren, a life member of the American and Michigan hospital associations, has served in various official capacities in addition to her long experience as a hospital superintendent.

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Miners' Medical Program

In a progress report on operations of its Welfare and Retirement Fund, issued at Washington headquarters in October, the United Mine Workers of America disclosed that its distinctive type of medical and hospital care program is making good headway. Among the comparatively few statistics given were the following:

During the 20 months in which the program has been in effect, up to June 30, 1951, approximately 2,000,000 hospital days have been provided for beneficiaries; $25,252,546.01 has been expended for physicians' and hospitals' services; current rate of hospitalization is approximately 4,500 patients under care each week.

The practice of the fund's medical-hospital program is to make arrangements with participating doctors and institutions, rather than to contract for enrollments in prepayment plans.

"General hospital and medical care in the hospital have been made available for miners and their dependents, for widows and orphans of miners throughout the coal mining areas, in conformity with fund requirements that the quality and cost of such care and services meet the professional standards of the fund's medical staff," says the report.

"In order to make this care and service available in conformity with requirements, the medical staff of the fund had to work out satisfactory arrangements with thousands of hospitals and physicians not only in every coal mining state, but also in many other states because of the inadequate facilities in coal communities."

Dr. Warren F. Draper, medical director, stated that most urgent needs are: (1) Good community hospitals to meet the requirements where there are none at all, or where existing hospitals are entirely inadequate; (2) more and better medical services in certain mining areas. Dr. Draper added "The availability of properly qualified physicians depends upon the adequacy of hospital and diagnostic facilities and provisions for housing."

Signifying its intentions of following up on these recommendations, The United Mine Workers Welfare and Retirement Fund has taken the lead in the formation of three voluntary associations which will build new hospitals in mining areas with assistance of loans from the fund. Sizes of the loans, terms and capacities of the proposed hospitals are details not yet disclosed.

Facts revealed to date are as follows:

Memorial Hospital Associations of Kentucky, West Virginia and Virginia have been formed. They have an interlocking directorate, comprising Dr. Dean A. Clark, general director of Massachusetts General Hospital and a medical adviser

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- Waterproof, not merely water-resistant.
- Tissue-thin, flexible, flesh-colored.
- Impervious to oil, grease or acids.
- Strongly adhesive . . . easily removed.
- Non-fraying.
- Economical — far outlasts cloth-backed tape.

HY-TAPE, originally developed and widely used in Europe, is now available from your surgical supply house in 12" (5 yd.) hospital rolls cut in 1, 1½, 2 and 3 inch widths.

Samples available on request from your surgical supply house.

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to UMWA; Dr. John T. Morrison, assistant to Dr. Draper; and the following laymen, all of whom are primarily identified with the union or its welfare fund: Edward L. Carey, Henry C. Daniels and Henry Combs.

The program calls for construction of new facilities in Harlan, Cumberland, Hazard, Pikeville, Jenkins and Wheelbright, in Kentucky; Beckley, Logan and Williamson in West Virginia, and Coeburn, Va. A statement by Washington headquarters of the fund said, in part:

"The fund is concerned with the quality of care provided its beneficiaries as well as with its cost. Existing hospital facilities meeting these fund requirements of service and cost will continue to be used to the fullest extent possible in the fund's efforts to meet the hospital needs of its beneficiaries. The continuing inadequacy, or total lack, of hospital facilities in certain coal mining areas of Kentucky, West Virginia and Virginia compel the fund, in order to discharge its obligations to beneficiaries in these areas, to arrange for the construction of new hospitals and hospital facilities."

Offices of the Memorial Hospital Associations have been set up in Washington at 1427 I Street, N.W.

Pittsburgh Program Accepted

The University of Pittsburgh's program in hospital administration was admitted to membership in the Association of University Programs in Hospital Administration at a meeting in September.

The University released its first class of residents this year.

Charter members of the association include the University of Chicago, Northwestern University, Columbia University, the University of Minnesota, the University of Toronto, Washington University and Yale University. Programs admitted in 1950 include the University of California, St. Louis University and Johns Hopkins University.

The purpose of the association is to improve the quality of graduate education in hospital administration offered through programs in universities. It was organized in 1948.

Dr. Bachmeyer is Emeritus

Dr. Arthur C. Bachmeyer, associate dean of the University of Chicago's division of biological sci-

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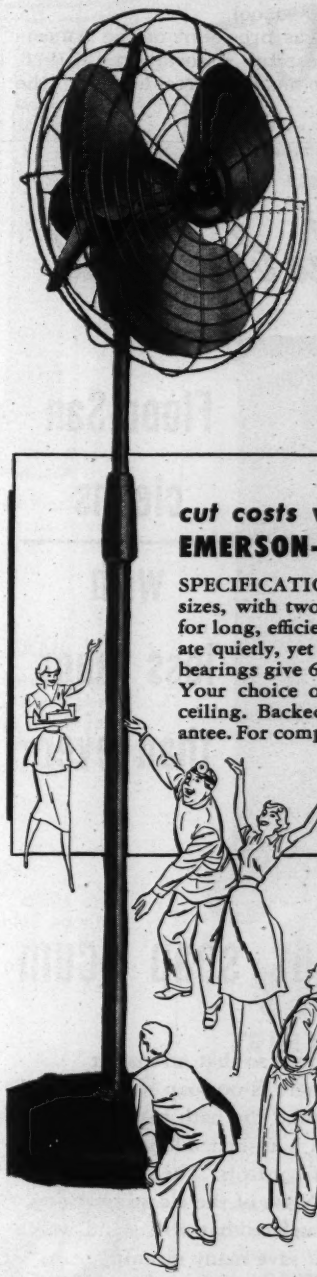

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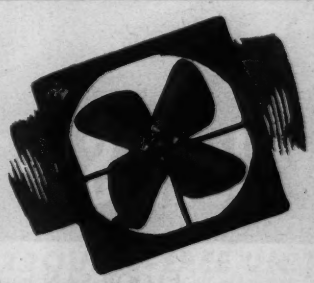

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ences, who became emeritus October 1, was honored at a dinner given recently by the university science division.

Dr. Bachmeyer, dean of United States medical educators, has served as a medical school dean for the last 26 years. He was appointed associate dean of the university's medical and biological division in 1935 and had previously served as dean of the College of Medicine of the University of Cincinnati from 1925 to 1934.

At the University of Chicago, Dr. Bachmeyer has served as director of the university's graduate program in hospital administration since 1935, and as a member of the student-selection committee of the medical school.

He was president of the American Hospital Association in 1926. He also has held presidencies of the American College of Hospital Administrators (1940) and the Association of American Medical Colleges (1951).

DR. BACHMEYER

Dr. George V. LeRoy, atomic specialist and alumnus of the University of Chicago Medical School, has been appointed Dr. Bachmeyer's successor as associate dean of the university's medical and biological division. He also will be associate professor of medicine.

Dr. LeRoy was director and organizer of the radioisotope unit at the Veterans Administration hospital at Hines, Ill., from 1947 to 1951. He supervised the biomedical program of the Eniwetok atomic-

DR. LEROY

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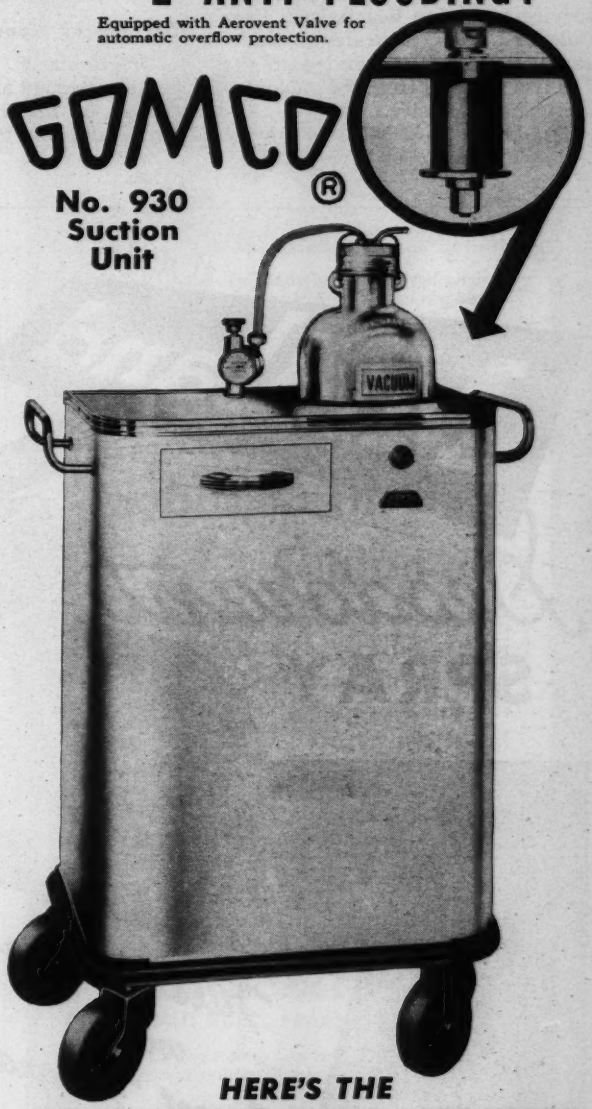

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weapons test for the Atomic Energy Commission.

As a lieutenant colonel in the United States Army Medical Corps, he served as chief of the medical service at station hospitals in New Caledonia, New Hebrides, Guadalcanal, the Marianas, and with the Twelfth General Hospital of Northwestern University.

Dr. LeRoy is a member of the Central Society for Clinical Research, the Chicago Heart Association, the American Federation for Clinical Research and the American Medical Association.

Dr. Buerki Honored

Dr. Robin C. Buerki, who recently resigned as vice president in charge of medical affairs at the University of Pennsylvania, was awarded an honorary degree of doctor of science by the university in September. The degree was conferred by Harold E. Stassen, president of the university.

Dr. Buerki now is executive director of the Henry Ford Hospital in Detroit. He was president of the American Hospital Association in 1936.

An excerpt of the citation read at the presentation follows:

". . . Your influence has radiated far and wide through this country and to South America as well. By extensive travel and continued investigation you have gained exceptional knowledge of hospital procedures and have stimulated the progress of postgraduate medical education. With remarkable energy you have given lavishly of your time to the problems of numerous medical councils, commissions, and committees, serving the federal government, national foundations, and leading professional associations. In these many activities your buoyant spirit and wise dynamic leadership have been strongly felt."

Dallas Hospital Fire

A midnight five-alarm fire broke out in St. Paul's Hospital, Dallas, Texas, late in October, but all of the 260 patients in the hospital were saved.

Nuns, nurses and volunteer workers carried and guided patients out of the hospital while the fire burned through the roof and fifth floor. Ambulances, police cars, taxicabs, and a city bus were used in the evacuation.

The fire was believed to have been caused by defective wiring. Sister Alberta is administrator of the hospital, which is operated by the Daughters of Charity.

Tumor Clinic Director

The appointment of Dr. Frank Sutherland Butler as director and associate visiting surgeon of neo-

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Laundry Institute

An Institute on Hospital Laundry Management will be conducted in Boston November 26-30. Applications still are being accepted. Tuition for the institute is $35 and covers the full cost of the educational program. For more information on the institute, see Laundry Management Comment on page 82 of this issue of HOSPITALS.

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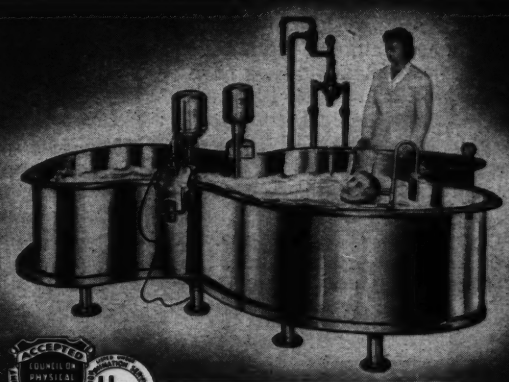

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plastic diseases at the recently opened Tumor Clinic of Columbus Hospital, New York City, has been announced by Dr. Victor Carabba, president of the medical board and director of the surgical division of the hospital.

Dr. Butler's hospital appointments include University and Bellevue as assisting attending surgeon of the tumor clinics. He also is an instructor at the University School of Dentistry and the Post Graduate Medical School.

Cause of Nurse Shortage

Licensed nurses must be freed from non-nursing duties if the nursing shortage is to be eased, reported Clara Quereau, secretary of the Board of Examiners of Nurses of the New York State Education Department.

"From 35 to 50 per cent of the time of licensed nurses is spent in carrying out non-nursing duties," said Miss Quereau at a meeting of the New York State Nurses Association. This situation, she said, is a major reason why private nurses are leaving the profession.

A solution offered was the training of auxiliary workers to take over such routine jobs as cleaning mattresses, making beds, answering phones and acting as hostesses for patients' guests.

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Acacia V Being Fattened

On November 2, during the Grand National Livestock Exposition, a purebred Hereford steer named Acacia V will be auctioned at San Francisco's Cow Palace. A weight-guessing contest precedes the auction.

Proceeds from both the auction and the contest will go to the Children's Hospital of the East Bay, Oakland, Calif., the only general hospital exclusively for children in northern California.

This is the fifth year a steer named Acacia has been donated by Mr. and Mrs. William Sidley of the Silver Spur Ranch, Encampment, Wyo., and fattened by Harvey McDougal of Collinsville, Calif., to be sold to help children needing medical care.

The Acacia project is sponsored by the Acacia Branch of the women's auxiliary of the hospital.

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Chicago—Kenner's Charitable Hospital, Inc.
Morrison—Morrison Hospital
Staunton—Community Memorial Hospital Association

INDIANA

Jasper—Memorial Hospital of Dubois County

LOUISIANA

Bogalusa—Desporte Clinic-Hospital
Church Point—Church Point Sanitarium
DeRidder—Frazar's Clinic and Hospital
Oakdale—Hargrove Clinic and Hospital

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Size of Shelves	15½x24	17½x27	15x24	18x27
Height	30½	31½	31	31
Over-all Dim.	15½x27x31½	17½x30x32½	16x27x32	18x30x32
Shelves	22 Gauge	20 Gauge	20 Gauge	20 Gauge
Uprights	20 Gauge	20 Gauge	16 Gauge	16 Gauge
Carrying Cap.	200 Pounds	200 Pounds	400 Pounds	400 Pounds
Shipping Weight	28 Pounds	37 Pounds	42 Pounds	48 Pounds
	$29.95	$37.50	$45.50	$51.00

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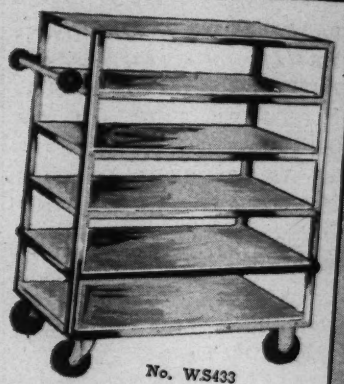

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SPECIFICATIONS	No.WS433	No.WS355	No.WS355B
Tray Size Accommodated	16½x22½	14x18	Same as No. 355 except it is equipped with strip bumper all around edges of 4th shelf
Bumper Equipment	Side Strip & Handle	Handle	
Shelf Size	21x35	18x31	
Height	50"	45¼"	
Clearance Between shelves	7½"	8½"	
Over-all Dimensions	23x40½x50	18x38x45½	
Shipping Weight	110 Pounds	83 Pounds	
Stainless Steel Shelves	20 Gauge	20 Gauge	
Stainless Steel Uprights	16 Gauge	16 Gauge	
	$119.50	$83.50	$89.75

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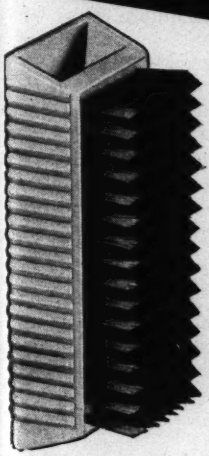

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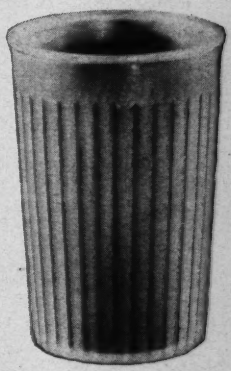

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